82-1217
No.

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1983

SEYMOUR R. MATANKY, M.D. and
CORBIN MEDICAL CLINIC,

Petitioners,

vs.

UNITED STATES OF AMERICA,
SECRETARY OF HEALTH, EDUCATION
AND WELFARE, AND BLUE SHIELD OF
CALIFORNIA, a corporation,

Respondents.

Judicial Review Pursuant to Article III,
U.S. Constitution and Title 28 U.S.C., Section 1491, and
Fifth Amendment, U.S. Constitution of Medicare Act, Part B
Claims Administrative Review

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT, AND TO THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA

JOAN CELIA LAVINE
Attorney at Law
123 North Hobart Boulevard
Los Angeles, California 90004
(213) 627-3241

Attorney for Petitioners
Seymour R. Matanky M.D., and
Corbin Medical Clinic

VOLUME I of II

QUESTIONS PRESENTED

1. Whether the Medicare Act, Title 42 U.S.C., Section 1395j, et seq., and particularly Title 42 U.S.C., Section 1395ff, inherently and as construed and applied, denies due process of law as guaranteed by Article III, United States Constitution and the Due Process Clause of the Fifth Amendment, U.S. Constitution where it is applied so as to deny to your petitioners Seymour R. Matanky, M.D. and Corbin Medical Clinic his medical business as assignees of Medicare Act, Part B claims, absolutely all federal judicial review by Judges duly appointed and sitting under Article III, U.S. Constitution of Medicare Act Part B constitutional claims alleged by your petitioners to arise under the Fifth Amendment, U.S. Constitution.

2. Whether the United States Congress is without authority to pass legislation as

contained in Title 42 U.S.C., Section 1395ff(b) totally precluding federal judicial review by Article III Judges of constitutional claims arising under the United States Constitution.

3. Whether claimants under Part B, Medicare Act, Title 42 U.S.C., Sections 1395j, et seq., are entitled to be heard under Article III of the United States Constitution to the same degree and extent as litigants in bankruptcy matters.

4. Whether the failure to permit the petitioner access to the Federal Courts, either in the United States District Court for the Central District of California or in the United States Court of Claims for review of his suit and claim on constitutional bases that his claims had been improperly reduced, constitutes a substantial, material, prejudicial violation of due process of law and the right to an Article III federal Judge under Article III and the Fifth Amendment of the United States Constitution, and was a

denial of the equal protection and equal application of the laws.

5. Whether the failure to permit the application of the Tucker Act, Title 28 U.S.C., Section 1491, providing for hearing and determination in the United States Court of Claims concerning Medicare Act, Part B payments and claims, so that physicans and patients may seek determinations and consideration of their respective positions by at least one federal judicial review of Article III judges under Article III, U.S. Constitution and the Fifth, Sixth and Seventh Amendments, U.S. Constitution, constitutes violations of said constitutional provisions and is a denial of the equal application of Title 28 U.S.C., Section 1491.

6. Whether permitting the Government to recoup and setoff later payments after the apparently applicable three-years statute of limitations and further reduce recovery by a physician who has accepted Medicare Act, Part B assignments

that have been reviewed, reduced and paid on previously, constitutes a substantial deprivation of property without due process of law in violation of the Fifth Amendment, U.S. Constitution.

7. Whether totally foreclosing the right of Medicare Act, Part B payment recipients and/or beneficiaries (doctors and their patients) from seeking independent federal judicial review by Judges who are duly authorized Judges pursuant to Article III, U.S. Constitution, after administrative determinations by hearing officers assigned by and paid by private parties who are insurance carriers is a substantial, material, harmful, prejudicial, per se violation of the rights of litigants involved to have access to the federal Courts and federal judgements under Article III and the Fifth Amendments, U.S. Constitution, when the applicable statute of limitations was expanded for the apparent purpose of this petitioner's claims and review.

8. Whether the constitutional issues involving the allegations of denials of due process of law were of the nature that petitioner was entitled to have evidentiary hearings and determinations on same by a duly authorized United States District Judge, and whether the United States Court of Claims had no jurisdiction to review or consider same or dismiss same and was required, on the motion of the petitioner, to have transferred the above entitled matter back to the United States District Court for the Central District of California. (Schweiker v. McClure, 72 L.Ed.2d 1 101 S.Ct.___) Whether the failure to transfer the above matter back to the United States District Court for review and consideration constituted acts in excess of the jurisdiction of the U.S. Court of Claims and was a violation of due process of law and the equal protection of the laws as guaranteed by Article III and the Fifth Amendment, U.S. Constitution.

9. Whether the dismissal of your petitioners' claims as part of the wholesale dismissal of all suits pending in the Court of Claims, involving applications for federal court judicial review of administrative determinations by the Social Security Administration, as made pursuant to Part B of the Medicare Act, Title 42 U.S.C., , Section 1495, et seq., on the ground that the federal courts lack jurisdiction to consider same pursuant to Erica, and without remanding the action to the appropriate U.S. District Court for litigation of the due process of law issues raised under the Fifth Amendment, U.S. Constitution, is arbitrary and capricious and whether same was plain error on the face of the record, and harmful, prejudicial, material, and substantial.

10. Whether the U.S. Court of Claims' dismissal of this action is contrary to the law as contained in Schweiker v. McClure, 72 L.Ed. 2d 1, 101 S.Ct.___ providing for determination of due process inssues by the approopriate federal district courts.

11. Whether the plaintiff was entitled as a matter of law to a hearing on the merits of his allegations of denials of due process of law, and whether it was material, substantial, prejudical, harmful, reversible, per se, plain error and violations of due process of law as guaranteed by the Fifth Amendment, U.S. Constitution for the due process issues to be litigated on a non-evidentiary proceeding on a motion to dismiss in the U.S. Court of Claims. (First National Bank of Arizona v. Cities Service Co., Inc., 391 US 253, 288, 20 L.ed.2d 569 (1968); Leone v. Aetna Casualty & Surety Co., 599 F.2d 566; Conley v. Gibson, 355 US 41, 45, 2 L.ed.2d 80 (1957); Cruz v. Beto, 405 US 319, 31 L.ed.2d 263 (1972))

12. Whether Matanky v. U.S. is distinguishable from U.S. v. Erika, Inc., 72 L.ed.2d 12.

13. Whether Matanky v. U.S. could be dismissed by the United States Court of Claims on a motion to dismiss, without an evidentiary adjudication on the merits pursuant to U.S. v. Erika, Inc., 72 L.ed.2d 12 and Schweiker v. McClure, 72 L.Ed. 1, 101 S.Ct.___.

14. Whether the U.S. Court of Claims, pursuant to other decisions in its court could dismiss the due process claims of the petitioners herein although these petitioners were not parties to those actions and they were therefore not binding on petitioners. Whether there was a failure to accord these petitioners notice and the opportunity to be heard in regard to the facts of other matters pending in the U.S. Court of Claims, and the concepts of collateral estoppel and res judicata could not be applied to these non-parties.

15. Whether the failure of the Medicare Administration to notify the parients whose claims were being adjusted for a second time and not paid on at all as a result thereof, or to notify subsequent claimants whose payments were being allotted to recoupment from the petitioner constituted and constitutes a denial of due process of law both to them as patients and to the physician, and particularly a deprivation of property without due process of law.

16. Whether the activation of a recoupment procedure well after the applicable statute of limitations constitutes a deprivation of proeprty without due process of law in violation of the Fifth Amendment, U.s. Constitution.

17. Whether U.S. District Court within the Ninth Circuit transferred the above entitled Medicare Act, Part B litigation to the U.S. Court of Claims on the basis that it had exclusive jurisdiction to consider the factual

metits of due process claims of plaintiffs-petitioners, and whether the U.S. Court of Claims committed substantial, material, prejudicial, harmful, per se, plain error in failing to transfer the due process portion of the above entitled matter back to the U.S. Dictrict Court for its adjudication when it held that it did not have jurisdiction to consider same. (Drennan v. Califano, 606 F.2d 850 (9th Cir.) Whether this denied the petitioners the right to be heard by an Article III federal judge, and denied the petitioners access to the federal Courts in violation of Article III, U.S. Constitution and the Fifth, Sixth, and Seventh Amendments, U.S. Constitution.

18. Whether the failure to provide the petitioners with a pre-recoupment administrative hearing procedure, where recoupment occurred in June, 1971 and audit started in 1974. Along with the withholding of funds amounting to $51,000 as of 1971, but the "audit" was not concluded until

1976 and there was no administrative hearing until 1978 on said recoupments, constituted a substantial, material, harmful, prejudicial, per se denial of due process of law in violation of the Fifth Amendment, U.S. Constitution. (Fusari v. Steinberg, 419 US 379, 42 L.ed.2d 521) Whether the administrative hearing was so lacking in speed and rapidness due to the fact that it could not occur until after an "audit" which was not concluded until about five years by the Medicare Administration that any prehearing recoupment was tantamount to no effective hearing or review by the massive delay and therefore amount to confiscation of property without due process of law and was arbitrary and capricious in violation of the Fifth Amendmant, U.S. Constitution.

TOPICAL INDEX

TABLE OF AUTHORITIES

Constitutions

Statutes

Miscellaneous

NO.

IN THE

UNITED STATES SUPREME COURT

OCTOBER TERM, 1983

SEYMOUR R. MATANKY, M.D. and
CORBIN MEDICAL CLINIC,

Petitioners,

vs.

UNITED STATES OF AMERICA,
SECRETARY OF HEALTH, EDUCATION
AND WELFARE, AND BLUE SHIELD OF
CALIFORNIA, a corporation,

Respondent.

Judicial Review Pursuant to Article III,
U.S. Constitution and Title 28 U.S.C.,
Section 1491, and Fifth Amendment,
U.S. Constitution of Medicare Act,
Part B Claims Administrative Review

PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF CLAIMS
AND TO THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA

Come now the petitioners Seymour R. Matanky, M.D. and Corbin Medical Clinic and petition this Honorable Court for a writ of certiorari directed to the United States Court of Claims, the United States Court of Appeals for the Federal Circuit and the United States District Court for the Central District of California to review and reverse and thereafter remand same for full evidentiary hearings in accordance with Article III, U.S. Constitution and the Fifth, Sixth and Seventh Amendments, U.S. Constitution after an order and notification dated October 22, 1982, the United States Court of Appeals for the Federal Circuit denying their petition for rehearing.

Your petitioners, a physician, Seymour R. Matanky, M.D., and a clinic, Corbin Medical Clinic, sought administrative review and independent federal judicial review of federal constitutional claims under the Fifth, Sixth and Seventh Amendments, U.S. Constitution

and Article III, U.S. Constitution, concerning about 2414 claims under the Medicare Act, Part B, made to the Medicare Administration between the years 1967 and 1973, pursuant to Title 42, U.S.C., Sections 1395 et seq. (known as the Medicare Act) for medical services to the elderly and otherwise qualified persons.

These 2414 claims, involving about 305 patients of your petitioners, had been previously reviewed, adjusted and reduced and thereafter paid on by the Medicare Administration, in about the sum of $50,899.00. On a second, further review by the Medicare Administration, with recoupment commencing in about June, 1971 and an audit starting in 1974, a prehearing recoupment procedure was initiated by the withholding of about $51,000.00 in later payments as setoff funds. These are the funds and procedures in dispute and in question.

Your petitioners have been unable to obtain an independent federal jucicial review of their constitutional claims pursuant to Article III,

U.S. Constitution or the Fifth, Sixth and Seventh Amendments, U.S. Constitution. After the action of your petitioners was transferred from the U.S. District Court for the Central District of California to the U.S. Court of Claims on the grounds that it was the federal court having jurisdiction, the U.S. Court of Claims dismissed your petitioners' action on the ground that it had no jurisdiction either, citing U.S. v. Erika, Inc., 72 L.Ed.2d 12, 101 S.Ct.

Your Petitioners raised an extensive number of federal constitutional issues, including the lack of right of the Medicare Administration to "recoup" funds after what appear to be the applicable statutes of limitations as being a denial of due process of law; the right of the patients on whose behalf recoupment procedures were initiated and whose funds were being used as setoff funds to notice and the opportunity to be heard; the lack of any fair, reasonable notice to your petitioners of which claims were

disputed or on what grounds; the application of guidelines not in existence during most, if not all of the time periods involved; the use of prehearing recoupment procedures commencing in about June, 1971 when any "audit" was not started until 1974 or completed until the year 1976, and a hearing did not take place until the year 1978; the medical necessity of the care and the right to be reasonably compensated for same in the absence of guidelines for same, to mention some of the constitutional claims involved.

JURISDICTION

Jurisdiction is conferred on this Court by Title 28, U.S.C., Sections 1255 and 2101(c), Article III, United States Constitution, and the Fifth, Sixth and Seventh Amendments, U.S. Constitution.

A copy of the opinion as issued by the United States Court of Claims on September 17, 1982 is attached hereto at Appendix "D" and the letter of the denying the application of the petitioners for rehearing dated October 22, 1982 is attached hereto and made a part hereof as contained in Appendix "D".

A copy of the complaint originally filled in the United States District Court for the Central District of California containing the various constitutional claims of your petitioners Seymour R. Matanky, M.D. and Corbin Medical Clinic is attached hereto and made a part hereto and made a part hereof as contained in Appendix "A".

CONSTITUTIONAL PROVISIONS, STATUTES AND RULES AND REGULATIONS INVOLVED

Article III, United States Constitution, Title 42, U.S.C., Section 1395ff, Fifth, Sixth and Seventh Amendments, Title 28, Section 1491, 20 CFR, Part 405 as published in the Federal Register, Volume 37, No. 2, January 5, 1972, pages 89-91, as set forth below and in the appendices attached hereto are the involved provisions, to wit:

Article III of the United States Constitution provides:

"Article III, U.S. Constitution"

"Section 2, Clause 1. Subjects of jurisdiction."

"The judicial Power shall extend to all cases, in Law and Equity, arising under this Constitution, the Laws of the United States, and Treaties made, or which shall be made, under their Authority, --to all Cases affecting Ambassadors, other public Ministers and Consuls; --to all Cases of admiralty and maritime Jurisdiction;--to Controversies to which the United

States shall be a Party;--to Controversies between two or more States;--between a State and and Citizens of another State;--between citizens of different States;--between citizens of the same State claiming Lands under Grants of different States, and between a State, or the Citizens thereof, and foreign States, Citizens or Subjects."

Until 1972 Title 42 U.S.C., Section 1395ff(b) read as follows:

> "Any individual dissatisfied with any determination under subsection (a) of this section as to entitlement under Part A or Part B, or as to amount of benefits under Part A where the matter in controversy is $100.00 or more, shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title, and, in the case of a determination as to entitlement or as to amount of benefits where the amount in controversy is $1,000 or more, to judicial review of

the Secretary's final decision after such hearing as provided in section 405(g) of this title."

Section 1395ff(b), however, was amended by the Social Security Amendments of 1972, Pub. L.No.92-603, Sec. 299(O)(a), 86 Stat. 1464 (1972) Section 1395ff(b) now provides:

Title 42 U.S.C., Section

"Section 1395ff. Determinations; appeals

(a) The determination of whether an individual is entitled to benefits under Part A or part B of this subchapter, and the determination of the amount of benefits under part A of this subchapter, shall be made by the Secretary in accordance with regulations prescribed by him.

(b)(1) Any individual dissatisfied with any determination under subsection (a) of this section as to--

(A) whether he meets the conditions of section 426 or 426a of this title, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this subchapter, or section 1395i-2 of this title or section 1819, or

(C) the amount of benefits under part A of this subchapter (including a determination where such amount is determined to be zero)

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 405(b) of this title and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1395cc(b)(2) of this title, shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in

section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.

Aug 14, 1935, c. 531, Title XVIII, section 1869, as added July 30, 1965, Pub.L. 89-97, Title I, section 102(a), 79 Stat. 330 and amended Oct. 30, 1972, Pub.L. 92-603, Title II, section 2990(a), 86 Stat. 1464.

The Fifth Amendment of the United States Constitution provides in relevant part, to-wit:

"No person shall . . . be deprived of life, liberty, or property, without due process of law; . . ."

STATEMENT OF FACTS

Your petitioners Seymour R. Matanky, M.D. and Corbin Medical Clinic engaged in an extensive

geriatric practice providing medical care and treatment to many persons covered by the Medicare Act, Title 42, United States Code, Sections 1395 et seq., during the involved and disputed periods of 1967 through 1973 for which claims assigned to them were filed with the Medicare Administration.

For the performance of the involved medical services your petitioners accepted assignments of Medicare benefits and applied to Medicare for payment, pursuant to Part B of the Medicare Act. That portion pays for 80 percent of the approved amounts.

During approximately June, 1971 a letter was sent to Dr. Matanky and Corbin Medical Clinic purporting to be notice of review. It read as follows:

> "Dear Doctor Matanky, we have been requested by the Social Security Administration to withhold Medicare reimbursement to you pending the

completion of an investigation of your claims to determine whether or not an irregularity exists. We will notify you when a decision is reached by Social Security Administration."

Between the year 1967 and June, 1971 many claims were paid on after having been reviewed, adjusted and reduced before approval of the amount payable, and your petitioners accepted the adjusted and reduced amounts in the approximate sum of $51,000.00.

During June, 1971, the Medicare Administration commenced a prehearing recoupment of $51,000.00. Much later, during 1974, it commenced a second, further review and reduction or elimination of payment on claims previously reviewed and paid on as described above.

The second review and audit of the involved claims did not terminate until the year of 1976.

No hearing whatsoever on the claims being subjected to the recoupment procedure

occurred until the year 1978 within the Medicare Administration. (See transcript of hearing, October 25, 1978 as set forth in Appendix "G" attached hereto and incorporated herein as though fully set forth.

The funds later withheld for setoff were payments on different claims and many patients were not the same ones involved in the original payments out. No notice was given to the patients whose claims the Medicare Administration sought recoupment and refunds concerning, nor was notice given to the patients whose payments were being used as the setoff funds, as best as can be determined from the records herein that their bills were effectively unpaid. The patients were also not given the opportunity to apply for review themselves independently of your petitioners.

Your petitioners raised numerous consitutional level claims in both the adminstrative hearing on October 25, 1978 and in the paperwork

and briefing involved therewith, and they thereafter raised substantial, federal consitutional claims on applying for hearing and review of the administrative determinations confirming the recoupment when they filed their complaint in the U.S. District Court for the Central District of California (See Appendix "A", constituting the complaint, filed on December 21, 1978.

The above action was transferred to the U.S. Court of Claims by the U.S. District Court, pursuant to a determination in the Ninth Circuit entitled Drennan v. Harris, 606 F.2d 850 which provided for no further hearing in the U.S. District Court under the assumption that the U.S. Court of Claims had the jurisdiction to review constitutional claims.

After this matter was transferred to the U.S. Court of Claims the U.S. Government answered the complaint. (See Appendix "B", being the answer of the Government herein.)

Your petitioners had also sued Blue Shield of California in the U.S. District Court.

The above entitled matter was stayed by the U.S. Court of Claims pending the outcome of the determination in U.S. v.Erika, Inc., 72 L.Ed.2d 12. The action of your petitioners was dismissed by the U.S. Court of Claims on the U.S. Government's application, on September 17, 1982, and their petition for rehearing denied on October 22, 1982, by the U.S. Court of Appeals for the Federal Circuit, pursuant to the determination of U.S. V. Erika, Inc. (See opinion of the U.S. Court of Claims opinion and the letter denying rehearing, dated October 22, 1982, attached hereto in Appendices "D" and "F".

Your peitioners continuously raised various constitutional issues including their right to be heard by an independent, duly appointed federal judiciary and pursuant to Article III

of the U.S. Constitution and concerning substantial federal constitutional issues not addressed in either U.S. v. Erika, Inc., 72 L.Ed.2d 12 or Schweiker v. McClure, 72 L.Ed. 2d 1. (See your petitioner's complaint and opposition to vacating a magistrate referral, set forth in Appendices "A" and "C" attached hereto)

None of the federal constitutional issues raised by your petitioners, as far as they can discern, were determined by either U.S. v. Erika, Inc., 72 L.Ed. 2d 12, 101 S.Ct. , or by Schweiker v. McClure, 72 L.ed.2d 1, 101 S.Ct. .

Your petitioners are now squarely faced with and squarely present to this Court the issue of whether they may be entirely precluded from seeking federal judicial review of federal constitutional claims concerning federal administrative determinations by the U.S. Congress or by a federal administrative procedure delegated to private insurance carriers and their employees,

or whether such a system clearly denies them due process of law and access to the federal courts.

ARGUMENT

I

A CONSTRUCTION AND APPLICATION OF TITLE 42 U.S.C., SECTION 1395ff(b) (MEDICARE ACT) TOTALLY PRECLUDING ANY JUDICIAL REVIEW BY JUDGES DULY APPOINTED AND SITTING UNDER ARTICLE III, U.S. CONSTITUTION OF SUBSTANTIAL CONSTITUTIONAL CLAIMS CONCERNING PAYMENTS MADE PURSUANT TO THE MEDICARE ACT, PART B, IS INHERENTLY AND AS CONSTRUED AND APPLIED UNCONSTITUTIONAL AND A VIOLATION OF ARTICLE III, U.S. CONSTITUTION AND DUE PROCESS OF LAW AS PROVIDED FOR BY THE FIFTH, SIXTH AND SEVENTH AMENDMENTS, U.S. CONSTITUTION. (WEINBERGER V. SALFI, 422 U.S. 749; CALIFANO V. SANDERS, 430 U.S. 109, 95 S.Ct. 2457, 45 L.ed.2d 522; JOHNSON V. ROBISON, 415 U.S. 361, 94 S.Ct. 1160, 30 L. ed.2d 389.

Your petitioners Seymour R. Matanky and Corbin Medical Clinic have been completely

precluded from obtaining any judicial review of their various constitutional claims concerning Medicare Act, Part B claims.

The United States Court of Claims dismissed their action and complaint based on U.S. V. Erika, Inc., 72 L.ed.2d 12, 101 S.Ct. , holding that it did not have jurisdiction to consider any claim, whether the claim was constitutional in nature or not. It declined to transfer your petitioners' action back to the United States District Court for the Central District of California for hearing of the constitutional level claims, which is the transferring District Court. The transferring United States District Court had originally transferred the above entitled matter to the U.S. Court of Claims pursuant to a Ninth Circuit decision, Drennan v. Harris, 606 F.2d 850, which provided for the transfer on the basis that constitutional level claims could be adjudicated by U.S. Court of Claims as the Article III Court

having jurisdiction of same.

This Court is now squarely faced with the issue of whether the U.S. Congress may completely preclude adjudication of constitutional claims concerning Medicare Act, Part B by Article III Judges and Courts on the one hand, and whether Title 42 U.S.C., Section 1395ff(b) is inherently and as construed and applied unconstitutional and in violation of Article III, U.S. Constitution and the due process clause of the Fifth Amendment, U.S. Constitution where it is applied so that no adjudication by a federal judge can be obtained in any federal court in this country, of Medicare Act, Part B claims.

The U.S. Court of Appeals stated in Drennan v. Harris, 606 F.2d 850:

> "We must therefore consider whether Salfi would preclude the district court from hearing Drennan's constitutional claims based upon

section 1331. The Supreme Court has recognized that a statute precluding all review of constitutional claims would raise a serious question of the validity of the statute. Sanders, 430 U.S. at 109, 97 S.Ct. 980; Salfi, 422 U.S. at 762, 95 S.Ct. 2457; Johnson v. Robinson, 415 U.S. 361, 266-67, 94 S.Ct. 1160, 39 L.Ed.2d 389 (1974) South Windsor Convalescent Home, Inc., 541 F.2d at 913; Gallo v. Mathews, 538 F.2d at 1150; Hazelwood Chronic and Convalescent Hospital, 543 F.2d at 707.

"This question was raised in a case similar to the present case in the Fifth Circuit, Dr. John T. MacDonald Foundation v. Califano, 571 F.2d 328 (5th Cir. 1978). There the court, sitting en banc, held that section 405(h) which is incorporated into

section 1395ii of the Medicare Act, does preclude all review of the Secretary's decisions by the federal district courts brought under section 1331, including constitutional claims. However, the Court there held that the difficult question of whether all judicial review of constitutional claims may be foreclosed is avoided, since jurisdiction has been held by the Court of Claims to exist in that court. Whitecliff, Inc. v. United States, 536 F.2d 347, 210 Ct.Cl. 53 (1976). The Fifth Circuit in MacDonald, thus remanded the case to the district court to dismiss with directions to transfer the cause to the United States Court of Claims. 571 F.2d at 332. This procedure has been approved and followed by our court. Sierra Vista Hospital, Inc. v. Califano, 597

F.2d 200 (9th Cir. 1979).

We find that the disposition suggested by MACDonald is the proper one. Accordingly, we remand this case to the district court with instructions to dismiss and transfer the cause to the court of claims."

The U.S. Court of Appeals for the Sixth Circuit concluded in Chelsea Community Hospital v. Michigan Blue Cross, 630 F.2d 1131 at 1135 (1980):

"We adopt the view of the Court of Claims, for it is a 'cardinal principle' that we should seek statutory constructions which avoid constitutional doubts, Johnson v. Robison, supra, 415 U.S. at 366-67, 94 S.Ct. 1165; St. Louis Univ., supra, 537 F.2d at 291. It would raise grave constitutional doubts if we held that the Secretary had unreviewable

discretion in reimbursing Medicare providers, particularly if this discretionary authority was delegable to private parties. See United States v. Aquavella, 615 F.2d 12, 18 (2d Cir. 1979); South Windsor, supra, 541 F.2d at 913."

II

WHERE THE MEDICARE ADMINISTRATION INSTITUTED A PREHEARING RECOUPMENT PROCEDURE IN JUNE, 1971, DID NOT BEGIN ITS REVIEW AND AUDIT UNTIL 1974 WHICH WAS NOT COMPLETED UNTIL 1976 AND THEN DID NOT CONDUCT HEARINGS UNTIL THE YEAR 1978, PREHEARING RECOUPMENT WAS A VIOLATION OF DUE PROCESS OF LAW GUARANTEED BY THE FIFTH AMENDMENT, U.S. CONSTITUTION.

The rapidity of administration review is a significant factor in assessing the constitutional sufficiency of the entire process. It can hardly be said that a recoupment of $51,000.00 in June, 1971 concerning which a review by the

Medicare Administration is not commenced at all until 1974, completed in 1976 and not scheduled for even administrative hearings in any way until 1978 is rapid. (Goldberg v. Kelley, 397 U.S. 254, 25 L.Ed.2d 2287, 90 S.Ct. 1011 (1970))

This Court stated in Fusari v. Steinberg, 419 U.S. 379 at 389, 42 L.ed.2d 521 at 529, 95 S.Ct. 533:

> "Identification of the precise dictates of due process requires consideration of both the governmental function involved and the private interests affected by official action. Cafeteria Workers v. McElroy, 367 US 886, 895, 6 L Ed 2d 1230, 81 S Ct 1743 (1961); Goldberg v. Kelly, 397 US at 263-266, 25 L Ed 2d 287, 90 S Ct 1011. As the Court recognized in Boddie v Connecticut, 401 US 371, 378, 28 L Ed 2d 113, 91 S Ct 780 (1971): 'The formality and procedural requisites for [a due process] hearing

can vary, depending upon the importance of the interests involved and the nature of the subsequent proceedings.' In this context, the possible length of wrongful deprivation of unemployment benefits is an important factor in assessing the impact of official action on the private interests. Cf. Arnett v Kennedy, 416 US 134, 168-169, 40 L Ed 2d 15, 94 S Ct 1633 (opinion of Powell, J.); id., at 190, 192, 40 L Ed 2d 15 (White, J., concurring in part and dissenting in part). Prompt and adequate administrative review provides an opportunity for consideration and correction of errors made in initial eligibility determinations. Thus, the rapidity of administrative review is a significant factor in assessing the sufficiency of the

entire process."

It is clear that there was an extreme delay and withholding of funds during the administrative audit which was delayed and did not even begin for about three years after the June, 1971 letter.

Your petitioners were entitled to a prompt review of any claims by the Government that funds should be reimbursed to the Medicare Administration. Because the claims involved people who were ill and elderly, rapidness of review was essential. Many of the patients had little time left in this world. The need for continuous medical attention was essential to their survival and there was likely to be an even greater impact on the quality of due process substantial if time lapses occurred in the hearing and determination processes.

In California there is a five-year statute requiring that a matter be brought to trial

within five years of the time that it is filed. Criminal cases now have much shorter time periods within which they must be brought to trial.

Yet, here there was a seven-year delay before a hearing was held. Such a delay hardly comports with due process of law when $51,000 in earnings is withheld from a person. This is a substantial amount of money by anyone's standards.

III

BY IMPLEMENTATION OF RULES AND REGULATIONS ON A RETROACTIVE BASIS WHERE THE MEDICARE ADMINISTRATION HAD REVIEWED, REDUCED AND PAID ON CLAIMS, IT INTERFERRED WITH THE CONTRACTUAL OBLIGATIONS BASED ON ACCORDS AND SATISFACTIONS IN VIOLATION OF THE RIGHT TO DUE PROCESS OF LAW AS GUARANTEED BY THE FIFTH AMENDMENT, U.S. CONSTITUTION

Legislation which impairs the obligation of contract is unconstitutional and a violation of the provisions of the Fifth Amendment, U.S.

Constitution (Lynch v. United States, 292 U.S. 571)

The Medicare Administration sought to apply rules and regulations which it propounded in 1971 to prior courses of conduct of your petitioners in doing work where there had been no rules or regulations outlining medical services it would provide for payment on. It had previously entered into accords and satisfactions of the claims by adjudicating, disputing and paying on them. (Union Pacific R. Co. v. United States, 99 U.S. 700, 25 L.ed. 496, 501 (1879)) The funds involved were and are property owned by your petitioners which the Medicare Administration took without adequate compensation.

Rights arising out of contracts with the United States are protected against action by it under the due process clause of the Fifth Amendment. Thus, in 1934 the Supreme Court through Justice Brandeis stated in Lynch v.

United States (1934) 392 U.S. 571, 781 L.3d 1434, 1440, 54 S.Ct. 840:

> "The Fifth Amendment commands that property be not taken without making just compensation. Valid contracts are property, whether the obligor be a private individual, a municipality, a State or the United States. Rights against the United States arising out of a contract with it are protected by the Fifth Amendment."

Congress is completely without power to abrogate contractual obligations of the United States. In 1879 the Supreme Court stated in Union Pacific R. Co. v. United States, 99 U.S. 700, 256 L.ed. 496, 501 (1879):

> "The United States are as much bound by their contracts as are individuals. If they repudiate their obligations, it is as much repudiation, with all

the wrong and reproach that term implies, as it would be if the repudiator had been a State or a municipality or a citizen."

California law on accords and satisfaction is as follows:

California Civil Code defines an accord as follows:

> "An accord is an agreement to accept, in extinction of an obligation, something different from or less than that to which the person agreeing to accept is entitled.' (C.C. 1521.)

California Civil Code defines a satisfaction as follows:

> "Acceptance, by the creditor, of the consdieration of an accord extinguishes the obligation, and is called satisfaction." (C.C. 1523.)

In other words, an accord substitutes a new executory contract

for a previously existing contract or debt, the usual purpose being to settle a claim at a lesser amount. (B. & W. Engineering Co. v. Beam (1913) 23 C.A. 164, 137 P. 624.) And, since an accord is an executory contract, it must be based upon a valid consideration. (Shortell v. Evans-Ferguson Corp. (1929) 98 C.A. 650, 277 P. 519; see Rest., Contracts section 417; 1945 A.S. 685; 1946 A.S. 630; 24 A.L.R. 1474; 62 A.L.R. 751.)

IV

ESTOPPEL AND THE VARIOUS OTHER DUE PROCESS ISSUES INVOLVED HEREIN WERE ISSUES OF FACT CONCERNING WHICH THE PETITIONERS WERE ENTITLED TO HAVE EVIDENTIARY HEARINGS BY ARTICLE III COURTS, AND WHICH WERE CONSTITUTIONAL FACTUAL ISSUES WHICH COULD NOT BE RESOLVED ON AN AT LAW MOTION TO DISMISS WITHOUT THE TAKING EVIDENCE.

The U.S. Court of Claims dismissed all of the constitutional factual claims of your petitioners, without any taking of evidence on them at all, by way of a non-evidentiary proceeding.

Your petitioners respectfully submit that such an approach to constitutional claims reduces the involved constitutional issues to a mere series of utterances which have no substantial meaning or enforceable validity in our legal system.

Your petitioners respectfully submit that issues of estoppel and the application of a statute of limitations barring recoupment by

the Medicare Administration are constitutional, factual issues to which they are entitled to be accorded evidentiary proceedings. (U.S. v. James Stewart Company, 336 F.2d 777, 779 (9th Cir., 1964)

But estoppel and the application of a statute of limitations were not the only factual issues raised to which your petitioners were entitled to evidentiary hearings. They asserted that the Government had entered into accords and satisfactions with them. They asserted protracted delay in providing for a hearing after recoupment occurred.

In Leone v. Aetna Cas. & Sur. Co., 599 F.2d 566, 567 (3rd Cir., 1979), the Court stated, citing this U.S. Supreme Court:

> "It is essential to emphasize at the outset that we are dealing with a judgment entered on the face of the complaint without affidavits and without discovery.

> It is the settled rule that 'a complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief.' Conley v. Gibson, 355 U.S. 41, 45-46, 78 S.Ct. 99, 102, 2 L.Ed.2d 80 (1957). See also Cruz v. Beto, 405 U.S. 319, 322, 92 S.Ct. 1079, 31 L.Ed.2d 263 (1972).[1] The question to be answered thus becomes whether the assertions of the complaint, given the required broad sweep, would permit adduction of proofs that would provide a recovnized legal basis for avoiding the statutory bar."

In Cooper v. Bell, 628 F.2d 1208, 1214, in talking of non-evidentiary dismissal concerning a bar to the complaint based on a statute

of limitations, the Court held that the plaintiff was entitled to be heard in evidentiary proceedings as to whether he was barred, and stated as follows:

> "We now turn to Cooper's specific allegation that the government should be estopped--by Holder's misrepresentation and by Cooper's reliance on Holder's advice--from raising Cooper's failure to file a timely charge. We appreciate the trial judge's astonishment at Cooper's allegation that he had relied on another's interpretation of EEO regulations with which Cooper's duties as an EEO officer should have made him quite familiar. Nevertheless, we cannot say that, as a matter of law, Cooper would not prevail were he able to adduce sufficient evidence to substantiate the allegation

Accordingly, it was improper to dismiss at this stage, because dismissal foreclosed Cooper from any opportunity to prove his case. See Jablon v. Dean Witter & Co., 614 F.2d 677, 682 (9th Cir. 1980)."

It is respectfully submitted that it was equally improper for the U.S. Court of Claims to have dismissed your petitioner's complaint and action.

V

THE INSTITUTION OF RECOUPMENT PROCEDURES WELL AFTER ANY APPLICABLE STATUTE OF LIMITATIONS RESULTED IN A TAKING OF PROPERTY WITHOUT DUE PROCESS OF LAW IN VIOLATION OF THE FIFTH AMENDMENT, U.S. CONSTITUTION.

Where a statute of limitations is expanded in such a way as to result in the deprivation of substantial property rights, a violation of due process of law as guaranteed by the Fifth

Amendment, U.S. Constitution results. (Campbell v. Holt, 115 U.S. 620, 29 L.Ed. 483; Chase Sec. Corp. v. Donaldson, 325 U.S. 304, 89 L.Ed. 1628)

Here both a lapse of time vested your petitioners with a settled property right and prejudiced them by the ability of the U.S. Government to recoup.

Your petitioners incorporate herein by reference as part of their argument their questions presented at the beginning of this petition and their complaint attached herein as Appendix "A".

WHEREFORE, your petitioners Seymour R. Matanky, M.D. and Corbin Medical Clinic pray that this Honorable Court grant their petition for writ of certiorari, granting them a hearing on this petition for writ of certiorari, and thereafter reverse and remand the above entitled action for hearing and determination at evidentiary proceedings before a federal judge duly

appointed pursuant to Article III, U.S. Constitution, and award your petitioners reasonable attorneys fees and costs herein.

Dated: January 18, 1983

Respectfully submitted,

JOAN CELIA LAVINE
Attorney for Petitioners

MORRIS LAVINE
617 South Olive St., Suite 510
Los Angeles, California 90014
Telephone: (213) 627-3241
Attorney for Plaintiffs
Seymour R. Matanky and
Corbin Medical Clinic

F I L E D
Dec. 21, 1978
U.S. District Court
Central District of
California

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

SEYMOUR R. MATANKY and CORBIN MEDICAL CLINIC, Plaintiffs, vs. JOSEPH A. CALIFANO, JR., SECRETARY OF HEALTH, EDUCATION AND WELFARE; and BLUE SHIELD OF CALIFORNIA, a corporation, Defendants.	CASE NO. 78 4887 WPG(K) COMPLAINT AND PETITION FOR REVIEW OF FINAL DECISION OF SECRETARY OF HEALTH, EDUCATION AND WELFARE RE WITHHELD FUNDS BY BLUE SHIELD OF CALIFORNIA

Come now plaintiffs Seymour R. Matanky and Corbin Medical Clinic and for their complaint and petition for review of final decision of Secretary of Health, Education and Welfare concerning funds withheld by Blue Shield of California allege as

follows:

I

This is an action to review a final decision of the Secretary of Health, Education and Welfare of the United States of America. This Court has jurisdiction of the action under Sec. 205 (g) of the Social Security Act, as amended (Title 42 U.S.C. Sec. 405 (g)).

II

Plaintiff, Seymour R. Matanky, is and has been at all times metioned herin, a resident and citizen of the State of California, residing at 19701 Arundel Place, Woodland Hills, California in the County of Los Angeles. He was duly licensed to practice medcine at all times pertinent herein in California.

The plaintiff Corbin Medical Clinic is a medicial clinic owned and operated by Seymour R. Matanky at all times pertinent herein and located at 19625 Ventura Blvd., Tarzana, California in the County of Los Angeles, and duly licensed in California.

The defendants are Joseph A. Califano, Jr., Secretary of Health, Education and Welfare and Blue Shield of California, a corporation.

Plantiffs contend that the defendants have wrongfully withheld $51,316.14 since June 15, 1971 in violation of plainitts' constitutional rights to due process of law and equal protection of the laws, and these sums are presently due and owing to him plus interest at the rate of seven percent per annum.

III

The plaintiff CORBIN MEDICAL CLINIC is located at 19625 Ventura Boulevard, Tarzana, California.

IV

Dr. Matanky was admitted to practice medicine in the State of Illinois in 1950, and subsequently joined the Medical Corps of the U.S. Army as a 1st Lieutenant and practiced for two years in Korea and Japan, and was subsequently discharged.

He was licensed to practice medicine in the State of California in 1954, and in 1957 he became

an assistant at the County General Hospital to Roger Egeberg, M.D., who was the Medical Administrator for Health, Education & Welfare. Dr. Matanky attended a large number of elderly patients at the County General Hospital for a period of nine years, becoming highly experienced and knowledgeable about their necessary needs for medical attention and an expert in that field.

Commencing in 1965, Dr. Matanky became engaged in attending the sick and the elderly in hospitals, skilled nursing homes, and rest homes located in the San Fernando Valley, consisting of various towns and cities in that area, to-wit: Encino, Tarzana, Sherman Oaks, Woodland Hills, Canoga Park, Reseda, etc., and made himself available at all times for all medically necessary needs of the area.

V

At the time of Dr. Matanky's commencement of his medical services, and for a period of years until 1972, there were no guidelines set up under the

Medicare program that informed the Doctor when he should render his services, nor limit to how many visits he could make to the facilities, and under what conditions these patients were entitled to treatment by Dr. Matanky as a medical necessity. The doctor, as a physician, was required to see and attend each patient in accordance with his best medical judgment.

VI

Each patient seen and given medical treatment and attention by the doctor was required to fill out and sign a contract in the form of a claim provided by Blue Shield and the Social Security Administration, and its Medicare section, and each claim form was separate contract and separately assigned to Dr. Matanky only on a place on the form provided for the assignment of the contract in the claim, "to the party who accepts assignment below." The party below named was Seymour R. Matanky, M.D., 19625 Ventura Boulevard, Tarzana, California 91356; no other provision was contained in the contract of assignment.

VII

As Dr. Matanky received these assignments from the patients who he saw and served, he turned them into Bule Shield, who processed them and reduced the amount claimed according to their determination that the services had deen duly rendered, and the charges were fair and reasonable and proper. Thereafter, they issued their check to Dr. Matanky, and Dr. Matanky received the same and accepted the reduced amount. This constituted an Accord and Satisfaction. (1 C.J.S. Sec. 34, 528; C.C.P. Sec. 1523; Williston on Contracts, revised, vol. 6, Sec. 1856, p. 5220; Silver v. Grossman, 183 Cal. 696; Grayhill Drilling Co. v. Superior Oil Co., 39 Cal.2d 751.)

VIII

In 1971, Medicare, for the first time, adopted guidelines and regulations limiting the number of visits which doctors could make to these facilities, effective in 1972. On June 15, 1971, Dr. Matanky received a letter from the supervisor of the program

integrity Medicare liaison stating that they had been requested by the Social Security Administration to withhold Medicare reimbursement pending completion of investigation ot determine whether or not any irregularity exists. They further stated that, "... We wil notify you when a decision is reached by S.S.A."

IX

No notice was given, nor hearing called, as required by due process of law guaranteed by the Fifth Amendment to the Constitutionn of the United States (Goldberg v. Kelly, 397 U.S. 254, 25 L.ed.2d 287), to determine any rights or any cause for withholding the funds.

X

On demand of Dr. Matanky for a Fair Hearing before an Administrative Judge, a hearing date was granted on August 7, 1978, at Los Angeles, California, before the Honorable Nahman Schochet, Medicare Hearing Officer, selected and employed by Blue Shield.

XI

On August 7, 1978, a hearing was held by the Blue Shield Hearing Officer, the Honorable Nahman Schochet, at which time Dr. Matanky was present with his counsel, and Blue Shield and the Secretary were represented by the law firm of Hazzard, Bonnington, Rogers & Huber, and John I. Jefsen; and Blue Shield by Claude Molaison, and by Dr. Julius Sherr, medical advisor.

XII

The sole issue presented by Blue Shield was the lack of medical necessity for the various visits.

The Fair Hearing case number was 78268, originally 77042.

XIII

The claimants, Dr. Matanky and Corbin Medical Clinic, raised several constitutional violations of due process of law under the Fifth and Fourteenth Amendments to the Constitution of the United States.

Plaintiffs contended that Dr. Matanky entered into a good faith contract through the insurance carrier Blue Shield, and Joseph A. Califano, Jr., Secretary of Health, Education & Welfare, to render

all services medically necessary that were required, and submit the claims signed by the Beneficiaries for payment. That the rights were contractual and protected by the Due Process Clause of the Fifth Amendment to the Constitution of the United States. They contended further it's a violation of due process of law to deprive an individual of previously vested contractual rights.

Claimants further contend that Blue Shield and its peer reviewers examined all claims and reduced them from a total of $81,901.48 to $51,316.14 as a settlement and an Accord and Satisfaction of the amount due to the doctor and his patients for their medical services, and that Dr. Matanky had forgiven approximately $30,000.00 as consideration for the Accord and Satisfaction, and the amount that Blue Shield did pay was accepted at the time and waived any possible irregularities in the form of the claims, or the data supplied on them.

XIV

Claimants also raised the denial of due process

of law in failure to give Dr. Matanky or Corbin Medical Clinic fair notice, or any notice, or hearing regarding the withholding of funds.

XV

They also raised the question of the bar of the statute of limitations, which was limited to a three-year period of time. Provider appealed Decision 00-76-12, also 20 C.F.R. Sec. 405, 1885.

XVI

Claimants further raised the points that the first decision rendered was res judicata.

XVI

Claimants maintain that the monies withheld are monies that were being paid for the care of other patients than those for services for patients already cared for and paid, and that neither Blue Shield nor the government had a right to convert those payments to pay previously considered claims, and that it was conversion by Blue Shield.

XVII

Dr. Matanky testified that he made the visit

and rendered the services and that they were medically necessary. There was no contradiction or rebuttal at the hearing. No good cause was shown for any redetermination. See 20 C.F.R. Sec. 1481.

Dr. Sherr was called by Blue Shield to testify. He said that he did not practice in the same area as Dr. Matanky. He further admitted that he had not talked to any of the patients personally or diagnosed any of them. The doctor testified that the basis for payment generally for more than one visit per month was adequate documentation (Blue Shield had waived any defect in documentation by an accord and satisfaction). He further testified that he did not start looking at the claims involved until 1974, and the claims that he looked at were current claims. He was not qualified and his opinion should be disregarded. Moore v. Belt, 34 Cal.2d 525; Bennett v. Los Angeles Tumor Institute, 102 Cal. App.2d 293; Huffman v. Lindquist, 37 Cal.2d 465.

Other issues raised by claimant are:

(1) Whether Blue Shield could withhold payment due to Dr. Matanky for service rendered on new and different individual contracts as recoupment of money paid to him for other patients.

(2) The failure to notify the original claimants, the new claimants, and the doctor, specifically what was claimed and what specific facts are relied on to reopen the claims, and whether such failure constituted a denial of due process of law as guaranteed by the Fifth Amendment to the Constitution of the United States.

(3) Whether the withholding of payment from Dr. Matanky constituted impairment of contract, protected by the Fifth Amendment to the Constitution of the United States, and constituted a bill of attainder and ex post facto law in violation of the Constitution of the United States.

(4) No notice was given to Dr. Matanky or to the patients whose subsequent or past claims were

involved that Blue Shield was seeking a readjustment of the claims allowed and/or paid concerning the fact that the Blue Shield was claiming the right to withhold funds claims for other services as reimbursement to itself for monies paid years past. (Mullane v. Central Hanover Bank & Trust Co., 339 U.S. 306, 94 L.Ed. 865; Armstrong v. Manzo, 380 U.S. 545, 94 L.Ed.2d 62.)

XIX

The hearing on August 7,1978, resulted in a decision by the Hearing Officer as follows:

> "Accordingly, it is the decision that of the $50,889.82 now withheld by the carrier:
>
> "$50,518.22 is to be applied to satisfaction of the refund due the government on the reviewed claims; and
>
> "$371.60 overwithholding is to be refunded to the claimant;
>
> all pursuant to Title XVIII of the Social Security Act, as amended, and regulations

and rules duly adopted thereunder."

XX

The Hearing Officer advised that his decision was final and the final judgment of Health, Education & Welfare. Nevertheless, we filled a petition for rehearing which the Hearing Officer informed us he would consider. Nevertheless, we are filing this petition to review within the 60 days allowed by Section 205 (g), Title 18 of the Social Security Act, as amended. We attach a copy herewith of the Decision of the Hearing Officer and we ask the Court to request the Secretary of Health, Education & Welfare and the Medicare Hearing Officer and Blue Shield of California to furnish the Court and counsel with a certified copy of the decision of the Hearing Officer of the Petition for Rehearing and any decision on the Petition for Rehearing. We also ask the Court to order the Secretary of Health, Education & Welfare and the Hearing Officer and Blue Shield of California to furnish the Court

with a certified copy of the tape recording verified by the Hearing Officer as a true and correct copy of the proceedings conducted before him on August 7, 1978.

WHEREFORE, Plaintiffs-Claimants respectfully petition this Court to review and reverse the judgment of the Hearing Officer denying the claims of the Plaintiffs-Appellants, and order judgment entered against Joseph A. Califano, Jr., Secretary of Health, Education & Welfare, the United States of America, and Blue Shield of California for the amount of $51,316.14, plus interest at 7% per annum since June 15, 1971.

DATED: December 19, 1978.

Respectfully submitted,

MORRIS LAVINE
Attorney for Planitiffs-Claimants
SEYMOUR R. MATANKY and
CORBIN MEDICAL CLINIC

NAHMAN SCHOCHET
MEDICARE HEARING OFFICER
Two North Point
San Francisco, CA 94133

October 25, 1978

Joan Celia Lavine, Attorney
617 South Olive Street, Suite 510
Los Angeles, CA 90014

Re: Seymour R. Matanky, M.D.

Payment Review (PARE) on multiple beneficiaries services May 1969 through June 1973, with beneficiaries' names, HIC numbers, and claim control numbers in the record exhibits and accounts.

Amount in controersy at hearing request: net Medicare refunds due of $50,889.82 (the net 80% paid on the total reviewed overallowances).

FAIR HEARING CASE NUMBER 78268 (originally 77042)

On August 7, 1978, hearing was duly held at Los Angeles, California pursuant to Part B, Title XVIII of the Social Security Act, as amended, and regulations, policy and guidelines duly adopted thereunder. The participants were:

claimant in person; his attorney/representative, Ms. Joan Celia Lavine, of the Morris Lavine and Joan Celia Lavine Law Office; Mr. Claude Malaison, representative of the carrier, Blue Shield of California; Mr. John I. Jefsen of the Law Office of Hassard, Bonnington, Rogers & Huber, the carrier's attorney; and Doctor Julius Sherr, M.D., a medical advisor who reviewed the claims and files herein for the carrier.

The record herein consists of:

Exhibit A, the original file and claim accounts, previously furnished claimant and his attorneys. Included are the claims from May 1967 through June 1973 (in 65 different months) which were questioned. Also included herein is an additional August 7,1978 letter with 15 pagers of Committee Case Computations attached to the Administrative Review Decision of September 30, 1976 mailed to Doctor Matanky (the claimant),

and to be associated with pages 16-18 of the file (Exhibit A).

Exhibit B: Carrier's 4 page June 1, 1970 Medicare Bulletin; Part B Intermediary Letter Number 70-32, Number 70, pages B5 through B9; and carrier's January 1971 Medicare Bulletin pages 10 and ff.

Exhibit C: 2 page May 1974 letter from Roy F. Nilsson, Program Evaluation Branch, to the carrier's director of Medicare Liaison and Hospital Review.

Exhibit D: Copy of December 4, 1969 letter, carrier's medical advisor to claimant regarding patient Edward Kurakowski.

Also subsequent pertinent correspondence, and attorney's briefs, with the hearing transcript.

The record herein was not closed as ready for decision until October 13, 1978, when

Morris Lavine's Repy Brief was received by the undersigned.

The hearing, unduly delayed for varied causes, was to furnish claimant his requested opportunity to explain his position herein with such additional evidence as was pertinent and not already on file to support his claim. It should be noted that the claims reviewed are not only in claimant's name alone, but may also be in his name d.b.a. or as successor to the Corbin Medical Clinic.

Claimant alleges that monies withheld by the carrier for Medicare services are due him without any further adjustment for alleged over-allowances resulting in the alleged overpayments.

HISTORY/BACKGROUND

Medicare reimbursements to claimant were withheld since June 1971 at direction of the Social Security Administration, Bureau of Health Insurance (now: Health Care Financing Admini-

stration, Medicare Bureau). The carrier was also directed to perform a post payment review of all claimant's services between 1967 and 1973 rendered in Skilled Nursing Facilities etc. The resulting determination was that claimant had been overpaid (net) $51,316.14, following review of 2,412 claims for 305 Medicare beneficiaries in Skilled Nursing Facilities, Nursing Homes, and Guest Homes; $1,634.72 withheld over that amount was paid claimant with an August 25, 1975 letter (Exhibit A, page 12). Since then the files have been rereviewed and reevaluated.

An Administrative Review was the next step, which reported net Medicare overpayment of $50,889.82, which is the amount in controversy herein, being the net anount of payments already withheld and required to properly adjust the Medicare payments made to claimant on the claims reviewed in this proceeding. $425.32 was refunded to claimant to keep the amount withheld to $50,889.82. (Exihibit A, pages 16-17-18).

The purpose of this proceeding is not to check on claimant's medical or professional ability. The object is to see that Medicare payments were not made in violation of Medicare rules and regulations. Such overallowances, followed by erroneous overpayments, resulted mainly from causes as:

Using the wrong RVS procedure number indicating a greater allowance due than is proper.

Insufficient or no documentation (which must accompany each claim) to justify larger than normal allowances either for certain medical or surgical procedures or for more than the normal limit of one visit a calendar month to a patient with a chronic fairly stabilized condition in a nursing home or such institution. Or "Only patient seen" omitted when required to be stated if billed for any procedure greater than #90341/#90441; otherwise allowable as #90341/#90441.

In case of multiple routine calls made in an exteded care facility, nursing home or guest home, the physician may charge as for a home visit for the first patient seen, and procedure #9018 (#90341) for for each additional patient; but the claimant must state thereon which one was the "First Patient Seen."

Claimant was advised at least as early as June 15, 1971 that, pursuant to request of the Social Security Administration, Medicare reimbursements were being withheld pending audit investigation (Exhibit A, page 1).

Claimant's attorneys have been involved herein at least since their May 3, 1974 inquiry found at page 2 of Exhibit A. (See also, in Exhibit A, pages 3-4; 20-21-22; and August 7,1978 letter with attachments.)

(Number of Claims Involved.) The original review was of 2,412 claims for 305 beneficiaries,

and the remaining reviewed claims then excluded from further consideration. During the administrative review and additional 29 claims were excluded from consideration. There thus remained 1,137 claims for 167 beneficiaries.

(Amount in Controversy Summary.) The original net overpayment reported was $51,316.14 and $1,634.72 overwithheld refunded on August 29, 1975. Then the administrative review reported the net overpayment due as being $50,889.82 and an additional $425.32 refund in October 1976. (With the hearing request claimant supplied some additional papers causing another recalculation, reducing the amount in controversy to $50,518.22, leaving an apparent $371.60 still due claimant as of the hearing date.)

Exhibit C, a May 1974 letter, reports that certain civil claims of the United States against claimant had been settled, precluding recoupment of money for the 46 claims included in the indictment. It was stated that this did not preclude

"recouping any overpayments made on other claims for Skilled Nursing Facility visits submitted by Doctor Matanky from 1966 ..." "We have notified Mr. Lavine (Doctor Matanky's attorney) and Doctor Matanky that the monies being held cannot be released until the Medicare overpayment on assigned claims is computed . . . The 46 claims included in the indictment should not be considered in arriving at the overpayment."

FINDINGS

Based upon careful review and consideration of the record herein, it is found as follows:

1. The hearing request herein was in the alternative: (a) for honoring an alleged "accord and satifaction" of refunds due from claimant in the amount $51,316.14, allegedly paid by claimant to carrier for the government; or (b) for the over $81,000.00 originally billed in the reviewed claims.

2. This entire proceeding follows the administrative review determination that claimant owed the government a refund of Medicare net overpayments amounting to $51,316.14 (which claimant alleges he agreed to).

3. There is no proof that claimant refunded this $51,316.14; this amount was withheld pending the government directed audit; and most of it is still withheld by the carrier.

4. The $51,316.14 originally claimed due from claimant (and alleged by him as subject to "accord and satisfaction") was upon rereview and reevaluation reduced to $50,889.82, but is stil withheld.

5. Upon additional documentation furnished later, another rereview and reevaluation reports the net refund due as being $50,518.22.

6. Claimant has furnished general information and opinion regarding some details of his pratice, but no additional information referring to specific claims as required by Medicare ground

rules, policies and regulations.

7. Upon this set of facts and state of the record, it appears that claimant has in reality been contesting the additional reductions of the amount he owed on the reviewed claims, and which he owed on the reviewed claims, and which he agreed was due therfor by adjustment.

8. In view of the above, and the proceedings being based upon the alleged accord and satisfaction which was the withholding or repayment of the first refund amount of $51,316.14, this decision is not discussing the other arguments presented by claimant and counsel.

9. $50,518.22 is the refund amount now due the government from withheld moneys.

10. $371.60 overwithholding is to be refunded to the claimant.

DECISION

Accordingly, it is the decision that of the $50,889.82 now withheld by the carrier:

> $50,518.22 is to be applied to satisfaction of the refund due the government on the reveiwed calims; and
>
> $371.60 overwithholding is to be refunded to the claimant;

all pursuant to Title XVIII of the Social Security Act, as amended, and regulations and rules duly adopted thereunder.

Nahman Schochet
Medical Hearing Officer
(415) 445-5662

NS:dm

cc: Blue Shield of California
Attorney John Il Jefsen
Doctor Seymour R. Matanky

VERIFICATION

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES) ss.

I, the undersigned, say:

I have read the foregoing PETITION FOR REVIEW OF FINAL DECISION OF SECRETARY OF HEW RE WITHHELD FUNDS BY BLUE SHIELD OF CALIF. and know its contents.

/X/ CHECK APPLICABLE PARAGRAPH

/X/ I am a party to this action. The matters stated in it are true of my own knowledge except as to those matters which are stated on information and belief, and as to those matters I believe them to be true.

/ / I am / / an officer / / a partner ____

/ / _____of _____

a party to this action, and am authorized to make this verification for and on its bdhalf, and I make this verification for the reason. I am informed and believe and on that ground allege that the matters stated in it are true.

/ / I am on of the attorneys for _____

a party to this action. Such party is absent from the county of aforesaid where such attorneys have their offices, and I make this verification for and on behalf of the party for the reason. I am informed and believe and on that ground allege that the matters stated in it are true.

Executed on December 19, 1978 at Los Angeles California.

I declare under penalty of perjury that the foregoing is true and correct.

SEYMOUR R. MATANKY

IN THE UNITED STATES COURT OF CLAIMS

SEYMOUR R. MATANKY and CORBIN MEDICAL CLINIC,	)	F I L E D
	)	Dec. 10, 1980
Plaintiffs,	)	Court of Claims
v.	)	No. 67-80C
THE UNITED STATES,	)	
Defendant.	)	

DEFENDANT'S ANSWER

For its answer to plaintiff's petition, defendant admits, denies and avers as follows:

1. The allegations contained in sentence one of Paragraph I constitute plaintiff's characterization of the suit requiring no response. The allegations contained in sentence two constitute conclusions of law requiring no response; however, to the extent that they may be deemed allegations of material fact, they are denied.

2. Denies the allegations contained in sentences one through three of Paragraph II for lack of knowledge or information sufficient to form a belief as to the truth thereof, except

that, pursuant to Rule 33, defendant avers that plaintiff lacks capacity to sue. Denies the allegations contained in sentence four and states that the defeendant herein is the United States of America. Denies the allegations contained in sentence five.

3-4. Denies the allegations contained in Paragraphs III through IV for lack of knowledge or information sufficient to form a belief as to the truth thereof.

5. Denies the allegations contained in sentence one of Paragraph V. Denies the allegations contained in sentence two for lack of knowledge or information sufficient to form a belief as to the truth thereof.

6. Denies the allegations contained in Paragraph VI for lack of knowledge or information sufficient to form a belief as to the truth thereof, except admits that medicare beneficiaries must file a claim or a doctor may file such a claim pursuant to an assignment from the beneficiary.

7. Denies the allegations contained in sentences one and two of Paragraph VII for lack of knowledge or information sufficient to form a belief as to the truth thereof, except admits that Dr. Matanky received assignments and Medicare payments on some of these assignments. The allegations contained in sentence three constitute conclusions of law requiring no response; however, to the extent that they may be deemed allegations of material fact, they are denied.

8. Denies the allegations contained in sentence one, except admits that by 1970 Medicare had adopted guidelines concerning doctors' visitations. With respect to the allegations contained in sentences two and three, defendant admits that the referenced letter dated June 15, 1971, was sent to Dr. Matanky. Defendant states that such letter is the best evidence of its contents and denies any of plaintiffs' references thereto which do not conform to the contents of that letter.

9. Denies the allegations contained in Paragraph IX and states that notice and hearing were given in accordance with 42 CFR Section 405.801 et seq.

10. Admits the allegations contained in Paragraph X.

11. Admits the allegations contained in Paragraph XI, except denies that the Secretary was a party or represented by counsel.

12. Admits the allegations contained in Paragraph XII.

13-18. The allegations contained in Paragraph XIII through XVIII contain plaintiffs' characterization of their postition at the administrative level and as such, require no response. However, to the extent that any response may be required, defendant states that the administrative record to which plaintiffs refer is the best evidence of its contents and to that extent, defendant denies any of plaintiffs' references thereto which do not conform to such record.

19. The allegations contained in Paragraph XVIV constitute plaintiffs' characterization of the administrative decision and as such, require no response. However, to the extent that any response may be required, defendant states that the administrative record to which plaintiffs refer is the best evidence of its contents and to that extent, defendant denies any nonconforming reference thereto.

20. The allegations contained in sentences one and two of Paragrpah XX constitute plaintiffs' characterization of portions of the administrative record and as such, require no response. However, to the extent that any response is required, defendant states that the administrative record is the best evidence of its contents and defendant denies any nonconforming reference thereto. Denies the allegations contained in sentence three. Sentences four and five of plaintiffs' petition require no response.

21. Denies that plaintiffs are entitled to the relief sought in the final paragraph of their petition or any other relief arising from allegations contained in plaintiffs' petition.

22. Defendant denies each and every allegation in the petition not heretofore admitted, denied, or otherwise qualified.

FIRST AFFIRMATIVE DEFENSE

23. This Court lacks subject matter jurisdiction over plaintiffs' claim.

SECOND AFFIRMATIVE DEFENSE

24. Plaintiffs' petition fails to state a claim upon which relief can be granted.

THIRD AFFIRMATIVE DEFENSE

25. In Fair Hearing Case No. 78268, the Medicare Hearing Officer upheld the action of the Social Security Administration in directing the withholding of certain Medicare reimbursements to plaintiff Matanky since June 1971. Such withholdings, in the amount of $50,518.22, were held to have been properly offset against Dr.

Matanky's obligation to the United States arising out of his receipt of erroneous overpayments under the program. A copy of the decision is attached to the petition. Such decision is final and binding upon plaintiff Matanky in this action (and upon plaintiff Corbin Medical Clinic to the extent such clinic is a proper party having an identity of interest with plaintiff Matanky) since the decision is not arbitrary or capricious and is supported by substantial evidence. (42 CFR Section 405.835.) Accordingly, defendant is entitled to judgment that plaintiffs' claims are barred by offset in the amount of $50,518.22.

FOURTH AFFIRMATIVE DEFENSE

26. To the extent plaintiffs seek to recover more than the $50,518.22 determined by the Hearing Officer to be due the United States, such claim is barred by the fact that such express amounts have been paid to plaintiffs.

FIFTH AFFIRMATIVE DEFENSE

27. Plaintiff Corbin Medical Clinic is not a proper party to this action.

WHEREFORE, defendant prays that plaintiffs' petition be dismissed and that defendant be granted such other and further relief as may be just and proper.

ALICE DANIEL
Assistant Attorney General
Civil Division

LYNN J. BUSH
Attorney, Civil Division
Department of Justice
Washington, D.C. 20530

Of Counsel:
HENRY R. GOLDBERG
Department of Health and
Human Services

MORRIS LAVINE
Attorney at Law
617 South Olive Street, Suite 510
Los Angeles, California 90014
Telephone: (213) 627-3241
Attorney for Plaintiffs

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

SEYMOUR R. MATANKY and CORBIN MEDICAL CLINIC, Plaintiffs, vs. JOSEPH A. CALIFANO, JR., SECRETARY OF HEALTH, EDUCATION & WELFARE; and BLUE SHIELD OF CALIFORNIA, a Corporation, Defendants.	No. CV 78-4887-WPG(K) OPPOSITION TO MOTION TO VACATE REFERRAL, AND INSTEAD TO MAKE A RECOMMENDATION TO THE DISTRICT JUDGE FOR A HEARING BY THE DISTRICT JUDGE, OR THE COURT OF CLAIMS Hearing: February 16, 1979 Time: 10:00 A.M. Before: Magistrate Kronenberg

TO ALL PARTIES OF THIS ACTION:

COME NOW the plaintiffs, and in response to the motion of the defendants to vacate the referral to the Honorable John R. Kronenberg, U.S.

Magistrate, move the Honorable Magistrate not to vacate the order of reference, but instead to recommend to the District Judge that he take jurisdiction to rule on the due process claims of the plaintiffs, and to hear the same; and, in his discretion, either rule on the same or refer the matter to the United States Court of Claims and transfer the etire matter to the Court of Claims in Washington, D.C., for further consideration and determination; and, in respect thereto, plaintiffs set forth as follows:

1. Plaintiff, SEYMOUR R. MATANKY, M.D., commenced his medical services for the Welfare program in 1967. There were no guidelines set up and the doctor, along with others, was left to use his best judgment as to the medical care and treatment of patients in the various expert nursing care homes and medical centers to which patients were transferred from hospitals, where they were attended daily by their doctors.

2. Medicare was billed regularly for the treatments, and payments were adjusted and reviewed by BLUE SHIELD and their peer reviewers and advisors, and each claim, after adjustment by BLUE SHIELD, was paid; and as readjusted and accepted by the plaintiffs as the checks were issued, there were 2,412 claims for 305 beneficiaries, reviewed, considered, adjusted, and paid. There was no evidence of overpayment or irregularity. Guidelines were first set up by the Department of Health, Education & Welfare in 1972, limiting the number of visits a doctor could make to patients outside of regular hospitals. In the reviews of the claims, the plaintiff allowed the cutting off of approximately $30,000.00 in their acceptance of the amount paid.

3. The doctor continued his treatment of Medicare patients inside and outside of the hospitals and in special nursing homes and nursing centers, and continued to bill Medicare

and BLUE SHIELD for services to new and different, additional patients.

4. Without notice, or hearing, or grounds therefore to DR. MATANKY, CORBIN MEDICAL CLINIC, or the patients, it was at this point that BLUE SHIELD began to withhold the monies due for the services rendered to the new patients. This was as a result of a letter dated June 15, 1971, that Medicare reimbursement to DR. MATANKY and CORBIN MEDICAL CLINIC be withheld pending an investigation.

5. No wrong doing was specified in the letter, and no hearing was held or called prior to the requirements of due process requiring a notice and a hearing. (Sniadach v. Family Financial Corp., 395 U.S. 337, 23 L.ed.2d 349; Wisconsin v. Constantineau, 400 U.S. 433, 27 L.ed.2d 515; Goldberg v. Kelly, 397 U.S. 254, 25 L.ed.2d 287.)

6. No evidentiary hearing was held at that time, and no review or any proceeding taken to

examine the claims until 1974; and no further notice and no payments were made of the claims by BLUE SHIELD, which continued to withhold the monies which were assigned to DR. MATANKY for services.

7. On demand of DR. MATANKY and CORBIN MEDICAL CLINIC, a Fair hearing was set up, which hearing was held on August 7, 1978, before a Hearing Officer selected by BLUE SHIELD; and a decision rendered on October 25, 1978, by the Medicare hearing Officer, selected, appointed, and paid by BLUE SHIELD.

8. The sole issue which the Hearing Officer considered set up in his opinion was:

> "The purpose of this proceeding is not to check on claimant's medical or professional ability, the object is to see that Medicare payments were not made in violation of Medicare rules and regulations."

9. The opinion does not state any substantial showing of evidence of any violation of any statute, rule, or regulation, nor what rules and regulations were in effect between 1966 and 1971, for there were none. Doctors were left to their required duties as physicians to determine necessary medical care. The Hearing Officer sought to decide the case on rules and regulations set up subsequent to that date, all of which were not involved in any of the cases in which the funds were being withheld. The Hearing Officer, in violation of the plaintiffs' due process rights, failed to decide that there was no evidence of any regulations which covered the doctor's and clinic's duties, or services thereof for which he was paid during the years that were being adjudicated, all of which was a violation of due process of law guaranteed by the Fifth and Fourteenth Amendments to the United States Constitution.

10. The Hearing Officer also failed to adjudicate that the Medicare Act and regulations limited the right of BLUE SHIELD and the government to proceed after three years. (Provider Reimbursement Manual, Section 2408.4 (7346); also see Sections 13,510.33 and 13,510.64.)

11. More than three years elapsed before any determination was made to $51,316.14, which had been withheld without evidence or explanation. The sum had been received by DR. MATANKY as an Accord and Satisfaction under both California and National laws. (C.C.P. Sections 1521, 1523, 1 C.J.S. Section 34528; Williston on Contracts, Vol. 6, Section 1856, p. 5230; Silver v. Grossman, 183 Cal. 694; Grayhill Drilling Co. v. Superior Oil Co., 39 Cal.2d 751, 753; Potter v. Pacific Coast Lbr. Co., 37 Cal.2d 592.

12. None of the previous payments were appealed from the reviews, and the government and BLUE SHIELD, having had one fair and full

opportunity on the merits of the claims, should not be permitted a second time, but should be bound by the principles of estoppel. (Bernard v. Bank of America, 19 Cal.2d 807.)

13. There was no evidence that any of the regulations or requirements which the Hearing Officer considered were ever published in the Federal Register.

14. There were several violations of due process of law guaranteed by the Fifth Amendment to the United States Constitution which required, and requires, access to the court as guaranteed by 42 U.S.C. Section 405(g).

15. The government moves to vacate reference to the Magistrate, pursuant to General Order No. 104-D, and in violation of Weber v. Secretary of Health, Education, and Welfare (9th Circuit), 503 F.2d 1049, and in the Supreme Court of the United States in Mathews v. Weber, 423 U.S. 261, 46 L.ed.2d 483.

16. In Weber v. Secretary of Health, Education, and Welfare, 503 F.2d 1049, the Court said:

"General Order No. 104-D adopted by the district court provides, inter alia, for reference to a full-time U.S. magistrate of all ' actions to review administrative determinations re (sic) entitlement to benefits under the Social Security Act and related statutes, including but not limited to actions filed under 42 U.S.C. Section 405(g)."

"... Appellant conceded at argument that the procedure followed under the rule objected to is for the magistrate to examine the wirtten administrative record and make a recommendation to the judge. The parties are advised of the magistrate's initial opinion and are afforded time to present objections. If objection be

made, an opportunity is given to present briefs and argument in support thereof. The magistrate may then revise his original recommendation or adhere to it. Under either contingency he then forwards his recomcomendation and the administration record together with a report or proceedings before him, if any, to the judge for final action.

"[2] As so applied, we hold that the delegated authority is well within the intent of Congress in adopting the Magistrate Act; that the judicial review contemplated by the Social Security Act is adequatley provided and that the procedure comports with the requirement of exercise of judicial power under Article III of the United States Constitution. Were the broad provisions of General Order No. 104-D to be resorted to in the type of judicial review before us, the Secretary might have grounds to complain. As applied, the rule is not

vulnerable to the attack here mounted." (Weber v. Secretary of Health, Education, and Welfare, 503 F.2d 1049 at 1051.)

17. In Mathews v. Weber, 423, U.S. 261, 46 L.ed.2d 483, the Court said, on page 491, as follows:

> "[1b] We need not define the full reach of a magistrate's authority under the Act, or reach the broad provisions of General Order No. 104-D, in order to decide this case. Under the part of the order at issue the magistrates perform a limited function which falls well within the range of duties Congress empowered the district courts to assign to them. The magistrate is directed to conduct a preliminary review of a closed administrative record -- closed because under Sec. 205 (g) of the Social Security Act, 42 USC Sec. 405 (g) [42 USCS & 405 (g)], neither party may put any additional

evidence before the district court. The magistrate gives only a recommendation to the judge, and only on the single, narrow issue: is there in the record substantial evidence to support the Secretary's decision? The magistrare may do no more than propose [423 US 271] a recommendation, and neither the Sec. 636 (b) nor the General Order gives such recommendation presumptive weight. The district judge is free to follow it or wholly to ignore it, or, if he is not satisfied, he may conduct the review in whole or in part anew. The authority -- and the responsibility -- to make an informed, final determination, we emphasize, remains with the judge." (46 L.ed.2d at 491-492.)

18. Since there were no rules, regulations, or guidelines covering the years 1967 to 1972, the Hearing Officer attempted to decide the case

retroactively on statutes and guidelines which covered subsequent transactions and which were not in effect during the periods when the various services were rendered; to change the conditions and establish rules, and reopen the payments of approved amounts constituted an expost facto determination of previously allowed costs, approved, and paid; and violated due process of law and equal protection of law.

19. In South Windsor Convalescent Home, Inc. v. Weinberger, 403 F. Supp. 515, the Court held that the retroactive application did not apply to recaptive reimbursements for accelerated depreciation during dates prior to the challenged regulations, and that such attempted recapture was not lawful, (403 F. Suppl 522.)

20. The Court quoted Justice Oliver Wendall Holmes in Blodgett v. Holden, 275 U.S. 142, at 149:

"I think it tolerably plain that the

act should be read as referring only to transactions taking place after it was passed. When to disregard the rule would be to impose an unexpected liability that if known might have induced those concerned to avoid it and to use their money in other ways."

21. The failure to give notice of the specific claims and the specific charges on which BLUE SHIELD justified its retention of the money, and the use thereof by it, was a violation of due process of law. The plaintiffs herein were entitled to full and adequate notice, as were the beneficiaries who were affected by the actions of BLUE SHIELD and the government.

22. No notice was given, and no evidentiary hearings were held, and neither the plaintiffs or any beneficiaries wete advised of the government's or BLUE SHIELD's objective during the three-years period in which the

statute and regulations required such notices to be served. (In re Oliver, 333 U.S. 257, 286; Cole v. Arkansas, 333 U.S. 196.)

23. It was a violation of due process of law to find that the money could be transferred on the basis of no evidence whatsoever in the record to support such a right. The charge that DR. MATANKY or CORBIN MEDICAL CLINIC had been overpaid was not established by any substantial evidence and was a sure denial of due process of law. It is as much a violation of due process of law to take money away from a person entitled to it, without any evidence to support the right, as it is to convict a man on charges not made and to punish him without evidence of his guilt. (See cases in Footnote in Thompson v. Louisville, 362 U.S. 199, 4 L.ed. 2d 654, 659.)

24. There is presumption that when Constitutional question are in issue, the availability of judicial review is presumed. (Cervoni v.

Secretary of Health, Education, and Welfare, 581 F.2d 1010, 1017; Califano, Jr. v. Sanders, 430 U.S. 99, 51 L.ed.2d 192.)

25. The district court may itself determine all issues or transfer the case to the Court of Claims, pursuant to 28 U.S.C. Sec. 1406c. (Dr. John T. MacDonald Foundation, Inc. v. Califano, 571 F.2d 328 (5th Circuit, 1978): South Windsor Convalescent Home, Inc. v. Mathews, 541 F.2d 1910 (2nd Circuit, 1976).) Jurisdiction in the Court of Claims under 28 U.S.C. Sec. 1491.

26. The Hearing Officer also disregarded the regulations providing for res judicata of all matters previously determined after three years. (Title 20, C.F.R. Sections 404.973 and 405.1855; Fifth Amendment to the Constitution of the United States; Bernard v. Bank of America, 19 Cal.2d 807.) The contract as accepted by DR. MATANKY and BLUE SHIELD were property protected by the Constitution of the United States,

and not even Congress has authority to repudiate the obligation of these contracts. (Perry v. United States, 294 U.S. 330, 79 L.ed. 912; Union Pacific v. Coal, 99 U.S. 700, 25 L.ed. 496, 501.) This procedure ws also a violation of due process of law and the equal protection of the laws under the Fifth Amendment to the Constitution of the United States.

WHEREFORE, plaintiffs pray that the Magistrate overrule the objection of the government and hold a hearing and make a recommendation fovorable to the plaintiffs in the District Court, or the transfer the matter to the Court of Claims.

DATED: February 9, 1979.

MORRIS LAVINE
Attorney for Plaintiffs
SEYMOUR R. MATANKY and
CORBIN MEDICAL CLINIC

IN THE UNITED STATES COURT OF CLAIMS

NO. 67-80C

SEYMOUR R. MATANKY, M.D., AND CORBIN MEDICAL CLINIC	)	Jurisdiction; Medicare; Part B.
v.	)	SEP 17 1982
THE UNITED STATES	)	

Morris Lavine, attorney of record, for plaintiff.

Benjamin F. Wilson, with whom was Assistant Attorney General J. Paul McGrath, for defendant.

Before FRIEDMAN, Chief Judge, DAVIS and BENNETT, Jugdes.

ORDER

PER CURIAM: Plaintiffs, a medical doctor and a medical clinic he owns and operates, seek amounts they say they were denied, under Part B of Medicare, for services rendered to

patients covered by Part B. Defendant moves to dismiss on the authority of United States v. Erika, 456 U.S. ___ (1982). All the points, statutory and constitutional, raised by plaintiffs to sustain the jurisdiction of this court, have been recently disposed of by this court in several prior orders granting defendant's motions to dismiss in comparable cases. See Regents of the University of Colorado v. United States, Ct. Cl. No. 518-80C (order of August 27, 1982); Drennan v. United States, Ct. Cl. No. 88-80C (order of August 27, 1982); Babcock Artificial Kidney Center, Inc. v. United State, Ct. Cl. No. 467-80C (order of September 10, 1982); Wanda Williams, v. United States, Ct. Cl. No. 696-80C (order of September 10, 1982)-- and the earlier decisions cited in those orders. Plaintiffs raise no new issues warranting separate discussion.

Plaintiffs' alterrnative request that the case be re-transferred to the United States

District Court for the Central District of California is governed by our recent decision in Berton Siegel v. United States, Ct. Cl. No. 119-81C (order of August 20, 1982). See Wanda Williams v. United States, supra.

Defendant's motion to dismiss is granted and the petition is dismissed. IT IS SO ORDERED.

SEP 17 1982

IN THE UNITED STATES COURT OF CLAIMS

SEYMOUR R. MATANKY, M.D. and CORBIN MEDICAL CLINIC, Plaintiffs, vs. UNITED STATES OF AMERICA, Defendant.	) CASE NO.67-80 C FILED U.S. Court of Appeals for the Federal Circuit OCT 1 1982 George E. Hutchinson Clerk

PETITION AND MOTION FOR RECONSIDERATION OF ORDER AND JUDGMENT OF DISMISSAL IN FAVOR OF THE DEFENDANT U.S.A. AND AGAINST THE PLAINTIFFS

Come now the plaintiffs herein Seymour R. Matanky, M.D. and Corbin Medical Clinic and petition and move this Honorable Court for reconsideration and rehearing of the order and judgment, filed September 17, 1982, dismissing the above entitled matter and entering judgment in favor of the defendant the U.S.A. and against these plaintiffs, on the following grounds and for the following reasons, to-wit:

1. As plaintiffs have previously argued, it is the position of these plaintiffs that they

are entitled to a trial by jury, a hearing and determination by an Article III Judge duly appointed within the federal judiciary. (Northern Pipeline Construction Co. v. Marathon Pipe Line Co., 50 L.W. 4892, 6-29-82; Article III, U.S. Constitution and Fifth, Sixth and Seventh Amendments, U.S. Constitution)

This Court, in its order, has not addressed the issue posed by these plaintiffs as to the right of the plaintiffs to be heard by Article III Judges either in this Court of Claims or in a U.S. District Court. It is respectfully submitted that this Court has overlooked this issue in making its rulings and decision, and that if considered, would compel this Court to grant reconsideration and rehearing and thereafter reverse its decision to dismiss this action.

2. This Court has referred to various orders in its order and decision which are not generally published to the best of this counsel's knowledge, which were not attached to this

counsel's copy of the order and decision sent to him and which have not been provided to this counsel for his review and consideration in making this petition for reconsideration and rehearing.

It is respectfully objected that reference to orders and citations not generally available and to which the plaintiffs and their counsel have not had access constitutes a denial of due process, and particularly the right to know the basis of this Court's decision in order to be able to petition for rehearing and/or thereafter petition for appellate review. (Fifth Amendment, U.S. Constitution)

Plaintiffs' counsel has sent to this Court a request for the copying of the involved orders, but has not received a response or copies of the orders referred to in the order of this Court.

3. In Making its motion to dismiss, the U.S. Government attached parts of various cases

concerning which these plaintiffs were not involved and which were generally incoherent and unidentifiable, and which further were so difficult to make head or tail of that they constituted no notice to these plaintiffs as to the grounds or bases for a motion to dismiss.

This Court will remember that the plaintiffs and their counsel are located in Los Angeles, California whereas this Court is located in Washington, D.C.

It is respectfully submitted that a motion to dismiss based on unidentifiable documents concerning which some of the Judges in this Court may have personal familiarity due to having ruled on same constitutes a proceeding which approaches being a Star Chamber one in which the arguments are kept secret from these plaintiffs so that they cannot respond to them. These plaintiffs object that this style and course of proceedings constitutes a flagrant denial of due process of law under the Fifth,

Sixth and Seventh Amendments, U.S. Constitution as well as Article III, U.S. Constitution. (Hovey v. Elliott, 167 US 409)

4. These plaintiffs have raised what constitute an extensive number of factual issues as to whether violations of due process of law have occurred, including whether recoupment procedures well after any applicable statutes of limitations were commenced, whether there was an extensive denial of notice to the claimants and patients and whether the treatment involved was medically necessary.

A motion to dismiss, being an at law or law and motion procedure, does not deal with or attempt to deal with factual issues which should be tried before a Judge and jury, at an evidentiary hearing.

Further, this U.S. Court of Claims does not have jurisdiction of the due process claims, which should have been heard by an Article III Judge in a U.S. District Court. (Shuttlesworth

v. Birmingham, 358 US 101, 3 L.ed.2d 145; Garner v. Louisiana, 368 US 157, 7 L.ed.2d 207)

WHEREFORE, the plaintiffs Seymour R. Matanky, M.D. and Corbin Medical Clinic hereby move for reconsideration and rehearing and thereafter for reversal of this Honorable Court's order and judgment of dismissal entered herein on September 17, 1982, and that this matter be transferred back to the U.S. District Court for the Central District of California for further hearing and trial on their complaint.

Dated: September 30, 1982

Respectfully submitted,

/s/ Morris Lavine
MORRIS LAVINE, Attorney
for Plaintiffs
123 North Hobart Blvd.
Los Angeles, California 90004
(213) 627-3241

82-1217

No.

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1983

SEYMOUR R. MATANKY, M.D. and
CORBIN MEDICAL CLINIC,

Petitioners,

vs.

UNITED STATES OF AMERICA,
SECRETARY OF HEALTH, EDUCATION
AND WELFARE, AND BLUE SHIELD OF
CALIFORNIA, a corporation,

Respondents.

Judicial Review Pursuant to Article III,
U.S. Constitution and Title 28 U.S.C., Section 1491, and
Fifth Amendment, U.S. Constitution of Medicare Act, Part B
Claims Administrative Review

SUPPLEMENTAL EXHIBITS TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF CLAIMS TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT, AND TO THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA

JOAN CELIA LAVINE
Attorney at Law
123 North Hobart Boulevard
Los Angeles, California 90004
(213) 627-3241

Attorney for Petitioners
Seymour R. Matanky M.D., and
Corbin Medical Clinic

VOLUME II of II

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT
717 MADISON PLACE, N.W.
WASHINGTON, D.C. 20439

October 22, 1982

GEORGE E. HUTCHINSON
CLERK

TELEPHONE: 633-6550
AREA CODE 202

Morris Lavine, Esq.
123 North Hobard Blvd.
Los Angeles, CA 90004

Re: Case No. 67-80 C
Matanky et al. v. United States

Dear Mr. Lavine:

The court denied today the petition for reharing in the above appeal.

Very truly yours,

/s/ George E. Hutchinson
Clerk

cc: David M. Cohen, Esq.
Department of Justice

NAHMAN SCHOCHET
MEDICARE HEARING OFFICER
Two North Point
San Francisco, California 94133

October 25, 1978

Joan Celia Lavine, Attorney
617 South Olive Street, Suite 510
Los Angeles, CA 90014

Re: Seymour R. Matanky, M.D.

Payment Review (PARE) on multiple beneficiaries services May 1969 through June 1973, with beneficiaries' names, HIC numbers, and claim control numbers in the record exhibits and accounts.

Amount in controversy at hearing request: net Medicare refunds due of $50,889.82 (the net 80% paid on the total reviewed overallowances).

FAIR HEARING CASE NUMBER 78268 (originally 77042)

On August 7, 1978, hearing was duly held at Los Angeles, California pursuant to Part B, Title XVIII of the Social Security Act, as amended, and regulations, policy and guidelines duly adopted

thereunder. The participants were: claimant in person; his attorney/representative, Ms. Joan Celia Lavine, of the Morris Lavine and Joan Celia Lavine Law Office; Mr. Claude Molaison, representative of the carrier, Blue Shield of California; Mr. John I. Jefsen of the Law Office of Hassard, Bonnington, Rogers & Huber, the carrier's attorney; and Doctor Julius Sherr, M.D., a medical advisor who reviewed the claims and files herein for the carrier.

The record herein consists of:

> Exhibit A, the original file and claim accounts, previously furnished claimant and his attorneys. Included are the claims from May 1967 through June 1973 (in 65 different months) which were questioned. Also included herein is an additional August 7, 1978 letter with 15 pages of Committee Case Computations attached to the Administrative Review Decision of September 30,

1976 mailed to Doctor Matanky (the claimant), and to be associated with pages 16-18 of the file (Exhibit A).

Exhibit B: Carrier's 4 page June 1, 1970 Medicare Bulletin; Part By Intermediary Letter Number 70-32, Number 70-32, Number 70, pages B5 through B9; and carrier's January 1971 Medicare Bulletin pages 10 AND FF.

Mr. Schochet:

On the claim of Seymoure R. Matanky, Doctor of Medicine, apparently doing business or has done business at the Corbin Medical Clinic. Multiple patients accounts on fault herein will not be listed or named at this time. This is Fair Hearing Case Number 77042 pursuant to Part B, Title XVIII of the Social Security Act as amended and regulations duly adopted thereunder. I am Nahman Schochet, Hearing Officer assigned to this case since the early summer of 1977. The claimant is present in

person represented by his attorney Joan C. Lavine. The carrier, Blue Shield of California is represented by Claude Molaison and attorney John I. Jefsen. Also present is Doctor Julius Sherr a medical advisor for the carrier who has reviewed the file herein. My information of the case is from the material contained in the file furnished the parties, this is quite bulky but it will be considered Exhibit A for the record to keep it separate from any additional Exhibits that may be submitted.

The proceedings are tape recorded, all statements made on record are subject to the Federal Regulations governing the giving of false evidence. The purpose is to furnish claimant his requested opportunity to explain his position with such additional evidence as is pertinent and not already on file to support the claim he made. Claimant alleges that moneys withheld by the carrier for Medicare services are due him without any further adjustments. Normally it is not

advisable and necessary to go into any details at this time but reciting some of the background facts should help avoid unnecessary repetition of history during the hearing, as well as refresh memories of those present that the claimant has considerable arguments already on record in the Exhibit.

Medicare reimbursement for claimant were withheldheld for at least since June 1971 at the direction of the Social Security Administration, Bureau of Health Insurance. The carrier was also directed to perform a post-payment review of all services between 1967 and 1973 rendered in skilled nursing and similar facilities. The resulting determination originally was that claimant has been over-paid somewhat over $51,000.00. $1,634.72 withheld over that amount was paid with an August 25, 1975 letter. Since then the files have been reviewed and re-evaluated. A September 1976 letter requests that 2414 claims involving services for 305 Medicare beneficiaries

were reviewed in so far as Medicare was involved with the reviews of all billings for services in skilled nursing facilities, nursing homes and guest homes. This was done by a medical advisor in claimant's specialty, evaluating the medical necessity of multiple visits. Pre-administrative review indicates as I have said over $50,889.82 overpaid and that apparently is our figure where we start today. From some experience in these cases, let me say on the record that such review is not to check on claimant's medical or professional ability or practice. The overpayments usually come from such causes as using the wrong procedure number, insufficient documentation, more visits charged to Medicare than allowable normally and such similar causes.
No argument is intended in this statement, it is simply a brief resume of the basic facts showing why the carrier performed this audit as directed by the Medicare agency and what the background is. Is this satisfactory for that purpose Ms. Lavine.

I'm not really asking for a commitment; this is just a general type background.

Ms. Lavine:

As far as it goes, yes.

Mr. Schochet:

And that's all the farther it is going to go. Is that alright with you Mr. Jefsen?

Mr. Jefsen:

Yes sir.

Mr. Schochet:

Alright, now then we can get down to the matter for which we're gathered. As you have been advised the procedure is fairly informal, we will withhold any technical arguments and try to get the facts on record for consideration. Now the claimant, Doctor Matanky, and his attorney at that time, Mr. Morris Lavine, asked for this hearing and after a number of difficulties we are finally gathered today. What should we put on to record, Ms. Lavine,

that is not there now to explain the claimant's position of this matter?

Ms. Lavine:

There are several items, your honor, first of all I think that we should consider the evidenciary matters which I understand will be put into evidence; all of the claims and copies of checks paid out and the information on them and the item called.....I am not sure, we were looking at it here earlier this morning. Labelled Hearing File Number 1, Fair Hearing Case Number 77042 is the title of it, Seymour R. Matanky, M.D. I believe that we need to take into consideration the various dates involved with notification, of what the notification consisted of, to whom notification was given and what regulations or rules were in effect that could adversely have effected Doctor Matanky at the time these various factual matters occured. Now I say this in a very conclusionary matter because I really need to

examine Doctor Matanky and go through these a little bit more specifically. Would you prefer that I do that now?

Mr. Schochet:

Well now let me pause there a minute; are you proposing at this time to go into all of those details that should have been done a long time before this, that should be normally established by the correspondence on file, by the notices to Doctor Matanky, by his objections, by the letters from your office? Isn't that repetitious and unnecessary?

Ms. Lavine:

Yes, I am just asking you if you would prefer that I do that, or we can just simply stand on the evidence that is, that I am pointing out to you that we had earlier discussed would be appropriate.

Mr. Schochet:

I think that if you believe there are serious errors affecting your clients rights they should

be pointed out. But to review the whole thing from A through Z, I think, would verge on nonsense at this time because it is not that type of hearing. You have the, Doctor Matanky according to my recollection, and this is without a final commitment until I re-review the file, has been on notice since the mmiddle of 1971, this has been in the nature of what the law refers to as an ongoing audit and as the correspondence back and forth and your firm has sent us some fairly lengthy and complete arguments from time to time and they have been read and I have read them all over and will do so again. So, I dont't see any point unless it is just to kill time and I am sure you don't want to do that. My idea of a hearing of this type is that, at this time, if there is anything that has been omitted from the file that is not sufficiently indicated even though it might be intimated that might harm the claimant's case, then I think you should put those on the record now.

Ms. Lavine:

Very well. I would like to point out to you various factual matters which appear to be very serious jurisdictional and due process omissions on a part of Blue Shield and the Social Security Administration. It appears to me from the record that although Doctor Matanky is right now characterized as the claimant, the original claimants who were the patients of Doctor Matanky have never been notified that there was a review going on after an initial determination had occurred. I cannot find any indication that any of his patients between 1967 and 1972 were ever notified of that. Second, it appears that what actually occurred was that Blue Shield, or the carrier, took payment from one set of patients and offset them against payment that has already been made, vis-a-vis, apparently another group of patients. Sometimes there may have been some general overlaping, it is hard

to tell, but there was apparently no notice to the subsequent patients involving subsequent applications for payment that their payments were being withheld from Doctor Matanky. I believe that the rules and regulations require at a reopening but all of the parties; and that includes the patients, be notified that this was occurring. That is my first concern. Now I have studied these rules and regulations concerning the suspension of payment and I understand that the only regulation that I can find that could have adversly affected Doctor Matanky was not published in the Federal Register until January 5, 1972, being in volume 37 starting at page 89 of the Federal Register. It appears that this rule required that Doctor Matanky be given notice and the opportunity to present evidence if you were going to be withholding, but this regulation does not appear to have gone into effect until after he was given notice of a suspension which I don't believe was

authorized by law. Even the provision that was put into effect as I understand it requires a conforming due process of law in that Doctor Matanky and the patients involved be given notice and the opportunity to be heard prior to any withholding of funds. This would mean that both the patients about whom there were payment disputes and the patients whose funds were going to be withheld for supposed recoupment be given notice. I do not find that this has been done at all from the record.

Mr. Schochet:

Just a minute, in regards to such claims, were these claims submitted in the name of Doctor Matanky?

Ms. Lavine:

Some were submitted in the name of Doctor Matanky, and some in the name of Corbin Medical Clinic.

Mr. Schochet:

Alright, so how was the patient involved in so far as the payment of these moneys was concerned?

Ms. Lavine:

How was the patient involved?

Mr. Schochet:

I mean Doctor Matanky was the person that billed, he was the person that asked payment, he was the person that complained of the adjustments or disallowances.

Ms. Lavine:

Your asking me what the involvement of the patient would be?

Mr. Schochet:

That's right.

Ms. Lavine:

The involvement of the patient is two fold.

Mr. Schochet:

But they were liable for the balances of course.

Ms. Lavine:

They were obligated for 20% of the bill to begin with but, I think there is something much more serious involved here. There was a contract between Doctor Matanky and his patients for Doctor Matanky to be paid a reasonable value of his services and I think the patient was entitled to know if his bill was not being paid according to the agreement that the patient had with Doctor Matanky I believe that any.....

Mr. Schochet:

Are you saying that Doctor Matanky did not notify them?

Ms. Lavine:

It wasn't Doctor Matanky's obligation to notify them.

Mr. Schochet:

In other words he did not notify them?

Ms. Lavine:

To the best of my knowledge no.

Mr. Schochet:

Ok. Now continue.

Ms. Lavine:

I do not believe that it was Doctor Matanky's obligation to have; the way I read the regulations, your honor, it was the obligation of the intermediary or Social Security Administration to have given notice.

Mr. Schochet:

Where did you find that?

Ms. Lavine:

Just a minute.

Mr. Schochet:

We are accepting this as argument.

Ms. Lavine:

This was only after the provisions went into effect. I don't find any provisions for suspension of payment prior to 1972 in the Social Security Administration regulations.

Mr. Schochet:

Ok. Continue.

Ms. Lavine:

May I point out that section to you at a little later time.

Mr. Schochet:

Yes.

Ms. Lavine:

Thank you. When I have had time to go through these regulations. Now, we get to another point involving review, and perhaps I should point out here that Mr. Jefsen has artculated that there was ongoing review involving an initial determination, but it is apparent that it was characterized as a recoupment for recovery procedure for supposed overpayment and I respectfully submit that this is actually a reopening of the various claims. The question becomes within what period of time, could these claims be reopened? Now that has caused me quite a little bit of problem in attempting to understand the various statutes of limitations involved but it would appear to me that

I can find no statement at all in the Federal Register referring to any right to reopen prior to about 1972. In 1972, I understand, that there was actually a provision instituted..... maybe I am misstating myself.....I'll have to check on the date on which the publication occurred.....

Mr. Schochet:

Did you run across anything under the title of Common Law Right of Recoupment in such cases?

Ms. Lavine:

I didn't research long enough on them.

Mr. Schochet:

There are some that are pretty involved. Go ahead.

Ms. Lavine:

The provisions that I did find though talked about the three year statute of limitation and for time periods commencing after May of 1972, there was.....No, I have misspoken myself,

for periods after December 31, 1971, there could be a reopening for three years prior and apparently what had to commence was a field audit within a three year time period as I understand the law. Prior to December 31, 1971, an audit, an indepth audit, had to occur or commence within a three year time period, if I understand the law to be correct, but again I want to point out to you I was unable to find anything published in the Federal Register about this three year time period prior to about 1971.

Mr. Schochet:

I thought you said 1972 earlier.

Ms. Lavine:

Yes. I said I misspoke myself.

Mr. Schochet:

1971 then.

Dr. Matanky:

On December 31, 1971.

Ms. Lavine:

That's right. I direct our attention to the Medicare/Medicaid guide in Commerce Clearing House. Paragraph 13510 discussing this matter and referring to a Medicare Intermediary Manual, Sections 2004 which I have never been able to locate and also referring within the Commerce Clearing House Medicare/Medicaid guide to paragraph 7635.87.

Mr. Schochet:

That's in Commerce Clearing House.

Ms. Lavine:

That's correct. Now the next question becomes what notice is adequate notice. As I understand it, the Blue Shield people, Social Security Administration believes a letter which is on page 1 of hearing file number 1 was intended to be notice and it reads, the body of the letter reads "Dear Doctor Matanky, we have been requested by the Social Security Administration to withhold Medicare reimbursement to

you pending the completion of an investigation of your claims to determine whether or not an irregularity exists. We will notify you when a decision is reached by Social Security Administration."

Now that is the body of the letter and it is signed Jane I. Csiteji, Program Supervisor, Program Integrity, Medicare Liaison, dated June 15, 1971. It is our position that this letter is not any due notice, reasonable or adequate notice to Doctor Matanky of which claims were being reviewed whether they were past claims or whether that would be the notice, of commencement of an ongoing audit of future claims, it did not give him any notice that he had the right to an evidenciary hearing or the right to review his. . . any disallowance of payments.

Mr. Schochet:

Just a minute, your putting in there as an assumption that the Doctor knew nothing at

all about Medicare, and had never been instructed as to its rules and regulations, had never been instructed as to its rules and regulations, had no experience therewith, but had to be notified every step of the way of all of these claims and the obligations of each party involved. Is that the implication there.

Ms. Lavine:

What I am saying to you is that this was not notice to him of which claims were being reviewed, but if whether there was any contest of prior claims at that time. I do not believe that this is a clear notice of which claims were being reopened, it does not use the word reopen, recoupment.

Mr. Schochet:

You also said they gave him no details of his rights; are you taking the position that he has to be read his rights at that stage of the game.

Ms. Lavine:

Yes, it is my position that he would be entitled to be notified that he had the right to an evidenciary hearing and he should have been given notice of where he could present evidence and under what circumstances. It's further, my contention that before any money was withheld from him he was entitled to a hearing, and I cite to your honor Goldberg vs Kelley, United States Supreme Court decision on that.

Mr. Schochet:

Just a minute. Wasn't that in a different field of law.

Ms. Lavine:

That's the principle applied.

Mr. Schochet:

Being favorable to the claimant of this case, but it was not applicable to this kind of a proceeding.

Ms. Lavine:

Well I believe that it is.

Mr. Schochet:

I thought that was a Welfare case, was it not . . .

Ms. Lavine:

It was a Welfare case.

Mr. Schochet:

Was SSI involved.

Ms. Lavine:

I don't recall that it was, no.

Mr. Schochet:

I think the limit of that and the later of the rules is strictly limited. I will have to double check that. What is your citation to that?

Ms. Lavine:

I will have to supply that to you later.

Mr. Schochet:

Your point there was that under Goldberv vs Kelly you should . . .

Ms. Lavine:

Yes. Prior to being deprived of property in the form of these Medicare payments for caring for these patients. Doctor Matanky was entitled to be notified of a right to a hearing and to be given a hearing at a reasonable time and reasonable place and in a reasonable way. I note that when there was a . . . I note that when there was a clarification or a publication of the Federal Register concerning the suspension of payments there was a provision starting with regulation number 5 of Section 405.370 through 405.372. My position is that I have a great deal of difficulty in understanding when Doctor Matanky was actually given notice of these recoupment procedures which until my father, Morris Lavine, commenced inquiries in 1974 as reflected by correspondence and I have difficulty in understanding how the three year time period is applied, how there can be any reopening at all.

Mr. Schochet:

Well, now instead of putting in pertinent evidence, what you are doing is repeating arguments which by the most part you have already made on record. Is that correct? Is that your intention now to list all your legal arguments? Or are you putting in evidence?

Ms. Lavine:

I'm arguing a point which does not appear clearly from the face of the records because you asked me to go ahead with pertinent points. Now I would like to ask Doctor Matanky to testifybriefly about his care.

Mr. Schochet:

About what?

Ms. Lavine:

About his care.

Mr. Schochet:

What do you mean by care? Care of the patients?

Ms. Lavine:

Yes.

Mr. Schochet:

Well, insofar as they apply to this specific . . . because when you say care of, I don't know if you mean his professional ability or . . .

Ms. Lavine:

No. The fact that he had made the visit and he believes they were medically necessary.

Mr. Schochet:

Go ahead.

Ms. Lavine:

Doctor Matanky just poked me and wanted me to point out to you a case which may be of help to you in studying this three year time period. It is in the new development volume of the Commece Clearing House, Medicare/ Medicaid Manual, and it's numbered 77-26.

Mr. Schochet:

What is the date of that publication please.

Ms. Lavine:

The date of the publication, lets see.

Mr. Schochet:

I mean where did you get it?

Ms. Lavine:

In the new development section.

Mr. Schochet:

Have you a photocopy of that page?

Ms. Lavine:

Yes I do and I think I also have a photocopy of the case.

Mr. Schochet:

Alright just a minute now. I just want to identify that page. What is the date that that page was published or distributed?

Ms. Lavine:

Either, probably in 1977 because it's from the new development. . .

Mr. Schochet:

Are you guessing. . . Let me see.

Ms. Lavine:

It's well because the date of the case is '77.

Mr. Schochet:

Well this was copywrite in 1978 and it's which period are you referring to on these two pages.

Ms. Lavine:

This page, that, that, and this.

Mr. Schochet:

That's on page 7641 and the date of the . . .

Ms. Lavine:

My law clerk has these two pages switched around this is the first page and this is the second page.

Mr. Schochet:

But normally at the top of every page in the CCH booklet of this type there is a date showing the week in which this was distributed that's what I am trying to find out.

Ms. Lavine:

I understand.

Mr. Schochet:

So I can locate it. So without that we will have to start at the very beginning.

Ms. Lavine:

Well I'll supply this to you in writing. But this has been compied from my own research I had not realized that you would like to examine it. We'll locate it for you and supply you with a copy of it.

Mr. Schochet:

Its not much of a reference. Continue.

Ms. Lavine:

Oh I'm sorry, I saw you writing. . . I didn't want to . . .

Mr. Schochet:

No I was just writing some notes. I thought you said you were going to ask Doctor Matanky some questions.

Ms. Lavine:

Yes. Doctor Matanky, concerning the patients that you saw between 1967 and 1973 that are involved with these claims, I want to ask you some questions generally that about your visits to them, were these for the most part, or were

these basically patients who were confined in hospitals or in convalescent homes?

Dr. Matanky:

That's correct.

Ms. Lavine:

And you saw these patients more than once a month for the most part as you've indicated in your claims, is that correct.

Dr. Matanky:

That's correct.

Ms. Lavine:

And why did you see these people more than once a month?

Dr. Matanky:

Well you mentioned '67 and I don't know whether there are some claims that they were auditing from '66 on too. But whatever the total number of claims from whatever period of time we are talking about. It's always been in my observation that the nature of caring for patients in Extended Care Facilities,

which these were, required a physician to be present and know what was going on to supervise the care and this could only properly be done by my presence. At least twice a week and sometimes more often and there were several reasons for this. First of all I have to identify the type of patients that we're dealing with. These were patients that were quite ill that had been in acute hospitals for the most part were daily attendance of these patients was necessary in order to insure that proper care, as required by hospitals of the acute nature and then they're transferred to Extended Care Facilities where their care was still quite necessary and urgent to continue their rehabilitation and maintenance of their health. There were several different levels of care that a Medicare patient was entitled to, one was acute hospital extended care facility and then if they required a lesser form of care, there was instituted a procedure by the Health Department where, they, with my

concurrance will put patients into what they would call intermediary care which is a lower level of care and none of these patients are in that level. They also go another step down to board and care where their ambulatory but not really able to take care of their total needs and so they are inboard and care facilities and then there are other Medicare patients who are strictly ambulatory and are office patients. So that these patients have to be categorized in a fairly ill type of patient requiring a considerable amount of care and attention for their various illness. And the other part of the problem is, is an ongoing thing that anyone has read the papers is familiar with the extended care facilities is totally aware of the really relatively poor level of medical care that is being given to these patients. This has hit the newspapers on many occassions. That the amount in trained personnel and so forth that they have in those facilities is, is something

to be desired. You have for the most part and still is an ongoing problem . . .

Mr. Schochet:

Just a minute, let's accept your statement is that your saying that in effect that for every single patient listed on all of these claims you found it necessary to visit them twice or more monthly . . .

Dr. Matanky:

Twice or more a week.

Mr. Schochet:

A week, alright . . .

Dr. Matanky:

For medical reasons.

Mr. Schochet:

Alright now continue.

Dr. Matanky:

Ok and for the additional medical reasons that they were not being afforded the same level of care that they were in acute hospitals. So that I would have to come in, find out if

the nurses and aids were carrying out my orders because frequently the level of trained personnel that was in these convalescent hospitals was much less then the acute hospitals you have people who . . .

Mr. Schochet:

I don't want to stop you doctor. I'll say this so far as I am concerned I am accepting your statement, your testifying just as though you are under oath, that for every single patient involved on all these multiple claims you found it necessary to visit them as often as you billed.

Dr. Matanky:

Right.

Mr. Schochet:

So there is no more details on that please. Now go ahead with anything else that you consider has been left off.

Dr. Matanky:

Alright that, that's my position if you want

to have to ask me any questions then I'll go from there.

Mr. Schochet:

Well now do you remember all of these patients?

Dr. Matanky:

I remember a fair number of patients but also I am trying to give you the general picture . . .

Mr. Schochet:

I understand your position your position is that these bills were justified and I'm not arguing with that . . .

Dr. Matanky:

That's right and their justified because of the fact that I, in order to render proper medical care which we're entrusted to do as physicians, we have to see these patients more frequently then what has been subsequently established as a rule.

Mr. Schochet:

Now your repeating yourself. In other words you are saying that Medicare rules does not

agree with your idea of the practice of medicine.

Dr. Matanky:

That's correct.

Mr. Schochet:

Alright so let us go ahead. Do you have anything else to say that has been omitted.

Ms. Lavine:

Yes, do you want me to . . .

Mr. Schochet:

I don't want anymore repitition because . . .

Ms. Lavine:

I appreciate that, I appreciate that. Mr. Jefsen, there was no dispute that he about his actually having made the visits is that correct?

Mr. Jefsen:

We are not questioning that at this time.

Mr. Schochet:

I reserve a right to question it.

Mr. Jefsen:

And I don't guess, no what I'm saying is that

I understand Blue Shield's position at the present time that they are not taking a position on that.

Mr. Molaison:

No, we were instructed by the Medicare Bureau to overlook, not overlook, not to consider the fact, that whether or not the services had actually been rendered but to reajudicate the claims strictly on the basis for the medical necessity for the number of visits rendered.

Mr. Schochet:

Do you have any questions to ask on that connection Mr. Jefsen?

Mr. Jefsen:

And what connection as to whether or not the claims were . . .

Mr. Schochet:

Were medically necessary and properly submitted.

Mr. Jefsen:

Maybe I'll . . . I think we can stand, Doctor Sherr if we cannot, just on the claims themselves

as they are submitted can we? Do you have any further questions you would want to ask of Doctor Matanky?

Dr. Sherr:

No I the claims just simply state that there are so many calls of the guidelines of the rules and regulations of Medicare and Blue Shield Medical Policy and Medicare's Bureau of Medical Claims and the Department of Health for Medi-Cal Claims give us certain guidelines, we have to follow those, and it's not just a doctor it's all doctors, including myself, because I to had a similar, almost identical type of practice.

Mr. Jefsen:

I have no further . . .

Mr. Schochet:

I have something I want to clear up I can't quite understand this fact on . . . Doctor Matanky you knew that you practiced under Medicare so far as these patients were concerned

or at least a portion of them did you not?

Dr. Matanky:

I, they were treated the same as any of my other patients.

Mr. Schochet:

No that doesn't . . . your evading the answer. Did you know that any of these patients were covered to any extent under Medicare?

Dr. Matanky:

Yes.

Mr. Schochet:

Alright that was my question. Were you at all familiar with Medicare rules?

Dr. Matanky:

Yes.

Mr. Schochet:

You knew that normally that only one visit a months was allowed to an institutional patient?

Dr. Matanky:

That is incorrect. Initially . . .

Mr. Schochet:

You did not know that?

Dr. Matanky:

That is not the rule or regulation or anything.

Mr. Schochet:

How would you state it then?

Dr. Matanky:

Initially in 1966 and 1967 there were many of us physicians and '68 and so forth has no guidelines from Blue Shield as to the number of visits that they wanted us to see the patients. These rules and regulations of one visit a month may be came on in 1971 something of this sort 1972 I don't recall exactly but this is long after the fact and we, among many other physicians, treated the patient according to what we thought was the medical necessity and what was good medical practice. As far as the rule of one per month that was a rule that came out, again, I am snot sure, maybe 1971 or 1972 and that rule is an

unfortunate rule, but that is about when it came out.

Mr. Schochet:

And did you honor that rule after it was adopted?

Dr. Matanky:

After it was adopted, I still continued to see my patients and I was probably seeing them about once a week and I was questioned informally and I told them well you pay me what you want but I basically want to see my patients so that I can know what is going on with these people in the convalsecent hospitals because I am appalled what is happening with the type of medical care that they are getting.

Mr. Schochet:

At that time were there any rules or facts to be divulged for example, if you saw only one patient on a visit to an institution or if you saw a number of patients?

Dr. Matanky:

This was only a Medi-Cal rule and we're speaking about Medicare at the present time.

Mr. Schochet:

There was no such Medicare rule . . .

Dr. Matanky:

As far as I know it was only applied and being told to me by the girl who fills out these forms that these were the Medi-Cal rule and was not a Medicare rule.

Mr. Schochet:

In other words you got that information from a girl who filled out the forms?

Dr. Matanky:

Yes. My office manager who, you know, I really didn't get totally involved with the mechanics of this I left this up to an office manager who would fill out these forms and try and guide me as to what the current rules and regulations were.

Mr. Schochet:

When you submitted bills for multiple visits, were there any additional comments made of the documentation? Did you list any other facts there?

Dr. Matanky:

Yes, we listed what we were treating the patients for and what . . .

Mr. Schochet:

That was on the bill, on the claim?

Dr. Matanky:

On the claim. But here my attorney is pointing out to me . . .

Mr.Schochet:

Well let the attorney point that out later just answer the question please.

Dr. Matanky:

The what?

Mr. Schochet:

I want you to try to stick to one thing at a time so that we can accomplish something.

Dr. Matanky:

Sure.

Mr. Schochet:

And you are starting to argue Law with me now.

Dr. Matanky:

Ok.

Mr. Schochet:

I asked you did you make any notes for example as to the condition as to the reason for the multiple visits and additional documentation other than a bill for a certain month that's all I want to know.

Dr. Matanky:

The only thing I listed was the diagnosis as I recall.

Ms. Lavine:

I don't think he understands you. Your referring to any place, where he made any other notations other then what's on the form.

Mr. Schochet:

No ma'am. I am not. The doctor said he was talking about the bills is that right?

Mr. Matanky:

Yes. That's correct.

Ms. Lavine:

Ok, excuse me.

Mr. Schochet:

And I am asking if on any of those bills you made any documentation as to the reasons for multiple visits; severities, some new condition, anything at all; and you say you recall, you think you did.

Dr. Matanky:

Yes, in the form of the diagnosis.

Mr. Jefsen:

I think maybe that was bothering me too. Was the diagnoses in all of these basically the same?

Dr. Matanky:

The diagnoses as a rule frequently was the same.

Mr. Jefsen:

Because that's my impression, Doctor Sherr, that basically that when we are talking about the number of visits per month the diagnoses was consistantly the same. Acute.

Dr. Sherr:

Well, usually it consited of a long list of diagnoses some chronic some acute and some not acute, some recent, but a long list repeated month after month after month.

Mr. Jefsen:

Visit after visit after visit.

Dr. Sherr:

Right.

Mr. Schochet:

Were they by patient or summary?

Dr. Sherr:

By patient, under the nature of illness or injury requiring servies of supplies.

Mr. Schochet:

Well that's what I have been trying to find

out. Now, what is it your lawyer wanted to . . .

Dr. Matanky:

Well, just to the time that the rule came down for one visit per month, and this was January 1, 1971.

Mr. Schochet:

What is your source for that?

Ms. Lavine:

Your honor, if I might hand it to you, this is from the letter from Blue Shield, it's on page 17 of the file #1, hearing file 1. I'll just hand it to you you can have a look at it here. This is a discussion about the various bases for dispute.

Mr. Schochet:

Well here it says, you are pointing this out as a rule?

Ms. Lavine:

No. This is the only guidance we have as to why and when they felt that only one visit

a month should be made.

Mr. Schochet:

And this is a letter dated in September on September 30, 1976 and you are now saying on record for your client, that this rule stated to be effective from 1967 through December 1970 was not known to your client until the last of September 1976? That whole paragraph? Isn't that what your saying?

Ms. Lavine:

No, that's not what I am saying. What I am saying is that the discussion . . . Doctor Matanky, . . . just a moment.

Dr. Matanky:

Ok.

Mr. Schochet:

Read the whole paragraph.

Dr. Matanky:

Ok, as far as the paragraph that I am referring to, the claims received after January 1, 1971 many . . .

Mr. Schochet:

No, that wasn't the paragraph that she pointed out to me.

Dr. Matanky:

That is the paragraph.

Mr. Schochet:

I thought you pointed out the one on . . .

Dr. Matanky:

No! No!

Mr. Schochet:

Alright.

Ms. Lavine:

I'm sorry.

Mr. Schochet:

Then we are referring to the second one claims received after January. Was that you first notice about them?

Dr. Matanky:

No I probably knew about that in '71 as I said, but that . . .

Mr. Schochet:

I always thought that first paragraph says that the patient must state on the claim form "Only patient seen" for an allowance of any procedure greater then certain numbers. Was that your practice?

Dr. Matanky:

This was first of all it was a practice that I left strictly up to my medical manager, you know, office manager, and I have recently, I personally don't know all these regulations nor these code numbers because I leave this up to my girls. I just recently asked my office manager Carmen about this first patient and subsequent patients and she told me this only applied to Medi-Cal patients and not Medicare patients. And this was just this last week, so I got to go on what she was telling me and . . .

Mr. Schochet:

You mean your taking your office girls word

instead of what's in the regulations affecting Medicare. Is that what your saying?

Dr. Matanky:

I don't know whether this affects Medicare or Medi-Cal.

Mr. Schochet:

Well do you know now? Whom are you dealing with at this hearing Doctor Matanky?

Dr. Matanky:

Medicare. Only Medicare.

Mr. Schochet:

Then what rules are to be presented at this hearing.

Dr. Matanky:

Ok the Medicare rule.

Mr. Schochet:

Then why do you bring Medi-Cal into it?

Dr. Matanky:

Well this is what she told me.

Mr. Schochet:

Because your office girl told you that. Now I

want to get one thing straight, you just testified that you left all the choice of the procedures numbers to your office girl.

Dr. Matanky:

That's correct.

Mr. Schochet:

And do you realize that that is probably where all the difficulty is?

Dr. Matanky:

Well I don't see . . .

Mr.Schochet:

At least a portion of it.

Dr. Matanky:

I sent my office girl to UCLA for extensive courses and all these things so that she is up all these regulations.

Mr. Schochet:

Well did you certify her to Medicare so that they should have accepted her word without question. Is that the idea?

Dr. Matanky:

I don't know what your referring to.

Mr. Schochet:

Well your taking position because she did this extra work, had this extra training; now whatever she did should have been binding under Medicare Administration.

Dr. Matanky:

Well I think she is knowledgeable and I . . .

Mr. Schochet:

I don't question that, but anybody can make mistakes and not every claim is involved so far as I know.

Dr. Matanky:

But in any event what I am saying is before 1971 there was no limitation on the number of visits to our patients. So that the audit review form '66 and on to '71 we had no knowledge that only one visit was being required. It was after January 1, 1971 that . . .

Mr. Schochet:

I have recorded your statement. Ok Ms. Lavine is there anything further?

Ms. Lavine:

Yes, I would like to ask Doctor Sherr a couple of questions if I might. Is that agreeable?

Mr. Schochet:

Are you through with Doctor Matanky?

Ms. Lavine:

Yes. At this point I am.

Mr. Schochet:

Well why not cover the whole ground or do you want to cover it piece meal?

Ms. Lavine:

I'd rather not do that.

Mr. Schochet:

Well go ahead and ask Doctor Sherr and we will see how it goes.

Ms. Lavine:

This is going to be very brief. Doctor Sherr when did you commence auditing Doctor

Matanky's Medicare claims?

"Unintelligible."

Mr. Schochet:

Just a minute everything you two are saying and whispering between you is going down into the record of the hearing. I just want you to know that but I want the attorney to put in the legal part . . . alright, Doctor.

Dr. Sherr:

The claims were reviewed by me from approximately January 1974.

Ms. Lavine:

When did you start working with Blue Shield to do that kind of work?

Dr. Sherr:

Oh I think I go back a little over six years.

Ms. Lavine:

Doctor Sherr, your a physician licensed to practice in the State of California?

Dr. Sherr:

Over 30 years.

Ms. Lavine:

Alright, you indicated . . .

Mr. Schochet:

Just a minute just a minute is it necessary to do that. Now I took the trouble to look up Doctor Matanky's qualifications in the AMA and I think you are just wasting time here. If you want to know go ahead if you haven't taken the trouble to look it up.

Dr. Sherr:

Also I think you have a statement answering question 2-6 presented by Doctor Matanky attorney to attorney.

Mr. Jefsen:

I think they were presented to myself and I quite candidly I don't know how thoroughly I may have answered these questions.

Dr. Sherr:

With regards to my background I thought you might have that.

Mr. Jefsen:

Well I have your background I'm not sure I supplied them with complete resume, Doctor.

Ms. Lavine:

I don't think you did.

Mr. Schochet:

There is a letter in the file, at least one letter to probably Mr. Morris Lavine, asking questions about myself, Mr. Jefsen I think, Doctor Sherr, and Mr. Molaison, anyway it's in the record. Go ahead please.

Ms. Lavine:

To the best of my knowledge we didn't receive, I recall receiving some descriptions about you, your honor. Mr. Jefsen did you send that?

Mr. Jefsen:

Candidly I don't think that I did send in the complete resume of Doctor Sherr.

Mr. Molaison:

There is some information in a letter dated . . .

Mr. Schochet:

Alright Ms. Lavine have you looked through the file?

Ms. Lavine:

The one that you have in your hand . . .

Mr. Schochet:

Your office correspondence.

Ms. Lavine;

And I think I've looked at just about everything.

Mr. Schochet:

Well, go ahead and ask the question.

Mr. Jefsen:

I do indicate that the medical advisor was Doctor Sherr, that he has been licensed in California since 1945 and his field is the general practice with a specialty in internal medicine. And he is a graduate of the California College of Medicine. And that's about the extent of the background I have given you.

Mr. Schochet:

What is that from so she can document it.

Mr. Jefsen:

Oh this is from my letter of October 19, 1977 to Mr. Lavine.

Mr. Schochet:

Is that satisfactory?

Ms. Lavine:

That's not really what I wanted . . . I wanted to inquire about his more recent exposure to Geriatrics Practice at the present, if you don't mind your honor. He's reviewing these claims as a medical advisor concerning Geriatric isn't that correct?

Mr. Schochet:

I do not know, are you taking a position that these are geriatric claims?

Ms. Lavine:

There basically that, yes.

Mr. Schochet:

That's on information from your client. That

will have to be limited, I don't think that its pertinent. Go on.

Ms. Lavine:

Doctor Sherr you have done a medical practice in the past that exposed you to considerable number of people who were confined in convalescent homes and who were elderly.

Dr. Sherr:

I found that when I got to Highland Park that 60% of my practice was geriatrics. Now that's a lot, that's more than most.

Ms. Lavine:

Do you still practice in Highland Park

Dr. Sherr:

No.

Ms. Lavine:

Are you pacticing in private practice now.

Dr. Sherr:

I had been until a treadmill test said stop for awhile

Ms. Lavine:

Now when did you stop . . .

Dr. Sherr:

Oh, just a few months, a couple of months.

Ms. Lavine:

So you entertain that during the 1960's and early 1970's you did a geriatric practice with about 60 percent of your patient.

Dr. Sherr:

A very active general practice.

Ms. Lavine:

Let's take a hypothetical, let's say I am 70 years old and I have had a stroke. I've been placed in a convalescent home by you. I'm not on Medicare, I'm paying you privately, and I have servere paralysis and I can't walk. I even have to be taken to the bathroom. But I'm stable. How frequently would you visit me a month, would you have during the early 70's have visited me?

Dr. Sherr:

First of all that's very, very hypothetical because if the patient has had a stroke, I don't think, if he just had a stroke, he certainly wouldn't be in a convalescent hospital. He would be in an acute hospital, until he was definitely stable to the point where he could be taken to a convalescent hospital.

Ms. Lavine:

Well let's say I had stablized sufficiently so that I didn't need the care of an acute hospital.

Dr. Sherr:

In an acute hospital we would see the patient almost daily. However, when we feel that there well enough to go to convalescent hospital we see that we admit them. We may see them once more that month, but generally, unless the patient has a problem, that is documented by the nurse or the patient has a temperature let's say bleeding . . . fell out of bed and

were notified, we respond at any time. Documentation is the answer. In other words, if there is a reason to see that patient, we can see them six times a month. But under ordinary circumstances when they are stable, they don't really need more than once a month care.

Ms. Lavine:

Then you feel that even if I were a private paying patient, now I'm not paying you through Medicare with no agreement for payment by that route. That you could adequately supervise me and make sure that I was doing as well as could be expected by seeing me just once a month?

Dr. Sherr:

Yes indeed, because your no farther than a telephone. You have to be able to rely upon your aids whether they are in an acute hospital or in a convalescent hospital.

Ms. Lavine:

Lets say that I were again over the age of 65, excuse me let me go back. Between the time period of 1966-1970, did you see your patients under the similar circumstances that I've described in the hypothetical, once a month in a convalescent hospital?

Dr. Sherr:

Generally yes. First of all most of the patients could'nt afford much more care unless it was absolutely necessary.

Ms. Lavine:

Was that the basis of why you didn't see them more than once a month?

Dr. Sherr:

No, the basis was whether they needed the care.

Ms. Lavine:

Highland Park is a rather average income area, isn't it?

Dr. Sherr:

That's a rather low income area.

Ms. Lavine:

Let me presume that I've gotten out of the hospital, I've been treated for diabetes and I'm over 65 and I'm a private paying patient. Would you see me more than once a month?

Dr. Sherr:

Not necessarily.

Ms. Lavine:

Not necessarily.

Dr. Sherr:

It depends upon the type of diabetes that the patient has, is it an insulin dependent diabetes?

Ms. Laveine:

Let me describe it to you. An insulin dependent diabetic, who is a brittle diabetic, in other words you know fluctuating severely under the Medicare regulations she would still be able to see the doctor more than once a month.

Dr. Sherr:

Compared to one who is, let's say, a fully stable diabetic, maturity onset, who is taking no medication, who is on diet alone or possibly maybe taking some oral medication and is well controlled. That patient doesn't even have to have a blood sugar but once every three months. Although, we do see them once a month. I think the regulations asked that we see them once a month. For the purpose Doctor Matanky mentioned that are they getting the proper care, looking at the records and things of this nature. But your brittle diabetic may need more care but that should be documented until the patient is stablized.

Ms. Lavine:

Your point is, that your trying to make with me is, that documentation is the key to whether or not doctor will be paid by Medicare.

Dr. Sherr:

That is the key to all payment as far as

Medicare or any other insurance company is concerned.

Ms. Lavine:

I have just one more question to ask of you for right now. Doctor Sherr, is the dispute right now over these claims involved in this hearing over the number of visits or over the amount that he was charging for the visits?

Dr. Sherr:

Well I don't think that the charges for the visits are of any importance to me, because it was my impression that the charges would be scaled down by the computer of Medi-Cal or Medicare as it went on through. I think there was a time that they paid the doctor for the total amount, whatever he billed, but I dont't think that that's the case now. But the number of visits without any documentation as to need, medical necessity would certainly have to be questioned, particularly if one bills for a single patient seeing visit by using

the RVS number that states that, and the law, the rules say, the guidelines say, that we must write only patient seen, if we see that patient alone. We might see sixty patients in one week or weekend, at some convalescent hospitals.

Ms. Lavine:

Thank you. There is one other questions I have to ask you before you were forced to stop your full time private practice, approximately how many patients do you have on the average each year? Between 1973 and 1977.

Dr. Sherr:

Well, you are forced to take more than you really want. But 30 to 40 patients a day, unfortunately.

Ms. Lavine:

In your office? Or throughout, between convalescent homes and in your office?

Dr. Sherr:

I'd say I'd include convalescent patients as well.

Ms. Lavine:

Thank you.

END OF SIDE TWO OF TAPE.#1

Mr. Schochet:

Well, I think we should have something on the record from Doctor Sherr as to the computations. What basis do you want to put that on Mr. Jefsen for the carrier.

Mr. Jefsen:

Alright, Doctor maybe even before we get there because I want to clarify in my own mind the answers that you gave to Ms. Lavine that were hypothetical questions, would your answers be basically the same if we were talking about the period of time from 67 through 70 as opposed to the 70s through 71, 72?

Dr. Sherr:

I think that if the claims are more or less comparable, definitely yes. But I have not seen, I don't believe I've seen those claims. The claims where there were four digits to the

RVS number, is that the ones your talking about?

Mr. Jefsen:

Yes.

Dr. Sherr:

Where as now there are five digits. I think there are very few of those that I saw at all of Doctor Matanky's. However, I've seen many of others and so, yes, I would say that they are comparable; it is just a matter of using the other case numbers.

Mr. Jefsen:

Can you very briefly describe for us how you proceeded through your review with Doctor Matanky's claims?

Dr. Sherr:

How I . . .

Mr. Jefsen:

Yes, just what the procedure was.

Dr. Sherr:

I proceeded to review laboriously. Because

claims have to be taken one by one, and you have to feel that it is your patient and so you first read the name and and have some idea of the age because it's a Medicare patient you know its geriatric and then you must look at the diagnosis and when you see that the diagnosis is a long protracted diagnoses desides taking time you have to go over it because among those there might be some clue as to the actual immediate necessity of seeing the patient. Like an acute this or that. When you see that the same diagnoses is repeated month after month after month and sometimes without even one single change of a word, you wonder how could a patient have an acute bronchitis for four or five months in a row. That doesn't . . . and four times a week. So, that is one of the bases on which we make up our mind. We also have regulations of the various agencies and we have the guidelines, like the one visit per month, and incidentally I think that you will find that even though the

doctor may not be individually advised officially by a letter from Blue Shield or such, we do have a Blue Shield letter that comes out for both Medi-Cal and Medicare; and in those changes of regulations and guidelines are listed and I remember that in our office we would take a flair red pencil and circle everything that referred to us because after all if it referred to an Eaucleation of an eye and we didn't even bother with it because we don't do it. If it referred to the number of visits, we circled it.

Mr. Jefsen:

Is the sum total, or your conclusion of your work, contained primarily in what they call the Calculation File Number 2?

Dr. Sherr:

That calculation file Number 2 . . .looking at it, looks like a maze to me. I'm pretty sure that it is, but there is no way of knowing exactly whether this is for any one paritcular

patient that I saw because you see obviously there are thousands of them.

Mr. Jefsen:

Yes. I gather in your review you did go through each set of claims and adjust each set of claims and look at the whole batch per patient as a whole.

Dr. Sherr:

Not just each set of claims but each and every individual claim.

Mr. Jefsen:

And when you finished with that information where did that then pass on to?

Dr. Sherr:

Well I left that with my aid and after it was changed and stamped with my stamp, I then gave those claims to my aid who then . . .

Mr. Jefsen:

There you are talking about the physical claims themselves.

Dr. Sherr:

My goodness, did I go through all those claims myself.

Mr. Jefsen:

Scares you. I think that's all I have of the doctor. I do have maybe just for everybody's edification, three documents which indicate in from June 1 of 1970 to 1971 the guidelines, and I like to call them guidelines more than regulations because it's not that you can't be paid for more than one visit per month, its that that's all you allow, your allowed without further explanation, both of them entitle Medicare. So I think maybe your office gal got confused and I would offer those.

Ms. Lavine:

Do I understand that this is the only form of publication and that it's not been published in the federal register?

Mr. Jefsen:

I'm sure it hasn't been published in that

format in the published register. I will not say that it has not been published in a different format in the register.

Mr. Schochet:

There is now accepted as additional evidence which will be grouped as Exhibit B, January 1971 and copy of the Medicare Bulletin from the California Physicians Service. Secondly on November . . . November 70 Part B Intermediary Letter #70-32 and a photostatic copy of a Medicare Bulletin issued by the carrier dated June 1, 1970 and these are all part B. These are being handed to Ms. Lavine so she can enter their titles.

Ms. Lavine:

Thank you.

Mr. Schochet:

Doctor Sherr before Ms. Lavine questions you, in going over these claims did you find any substantial differences in procedure numbers or amounts to be allowed over what was paid?

Dr. Sherr:

Differences in procedure numbers

Mr. Schochet:

Yes. The RVS procedure numbers.

Dr. Sherr:

Yes there were numerous RVS numbers that had to be changed. A great many of them were absolutely correct. However, the amounts are not changed by us. The doctors usually charges his what we consider as his usual and customary fee.

Mr. Schochet:

In other words you did not change the amount, you just changed the classification of that service, and then, am I to understand that if any amount was changed as the correct amount due that was done by a computer service later by the carrier?

Dr. Sherr:

Yes.

Mr. Schochet:

Is that the way it works?

Dr. Sherr:

I believe so.

Mr. Schochet:

Well, that's what I wanted to know.

Dr. Sherr:

Because the number may of been inappropriate so we changed it to a more appropriate number that would describe . . . would fit the service described.

Mr. Schochet:

Were you ever given a report as to what those totals amounted to or your work was just checking on the proper procedure numbers and those things are set in the amount changed?

Dr. Sherr:

If I'm not mistaken, my aid showed me a letter, a single letter, sometime ago stating a certain amount of recoupment. I don't recall what that total amount was, but I did recall that she

she put that across my desk. I don't have copies of them with me.

Mr. Schochet:

Your concern was then with only reclassifying these to see that the services were billed properly in accordance with Medicare rules so the proper payment would be allowed.

Dr. Sherr:

That's correct.

Mr. Schochet:

And that's the sum total.

Dr. Sherr:

That's right, that's exactly right.

Mr. Schochet:

Now Ms. Lavine you want a little recess so you may look those over or just make notes of them.

Ms. Lavine:

Yes I would like to read them over, could I have perhaps a minute or two?

Mr. Schochet:

Lets have a short recess while Ms. Lavine may look over these new Exhibits, So she can question Doctor Sherr.

Mr. Schochet:

Back on record again. I think we left off just where you were to start questioning Doctor Sherr or to continue.

Ms. Lavine:

Thank you your honor. Doctor Sherr, and if I might, your honor, I want to disgress back to what I planned to originally ask Doctor Sherr about when he started auditing or reviewing these records. Can you recall whether you were reviewing later records when you first started reviewing Doctor Matanky's records in January 1974?

Dr. Sherr:

No, I really can't tell you exactly, there are just so many that it's impossible for me to know, but it seems to me that they were the

claims as they came through. The current claims of that time. Now claims are generally anywhere from 30 to 90 days off. I think about that, maybe 60, something like that, so they were the claims that were current claims from a few months back.

Ms. Lavine:

I see. Thank you, and Doctor Sherr you were, or you have been in the past 3 or 4 years, working with Doctor Matanky's assistant in his office, Carmen, on how to prepare these claims and when it's appropriate for billing purposes. Haven't you?

Dr. Sherr:

No, I called from time to time, when there was a question, for instances a patient was hospitalized and surgery was done by another surgeon and usually the RVS number for the surgery includes the admitting of the patient to the hospital and all of the post-operative care so that another doctor does not and

cannot bill for admission and the post-operative care, because there would be two doctors, the surgeon and lets say the general practitioner or the internist. Unless there is documented evidence that, that care was needed, so I have to call from time to time and ask a few questions.

Ms. Lavine:

I see.

Dr. Sherr:

That was really the major extent. There was no educational conferences which is really the field we are in here and we try to get the doctors together for conferences.

Ms. Lavine:

I see. In other words you were discussing with her current claims that Doctor Matanky or Corbin Medical Clinic would supply.

Dr. Sherr:

At that particular time.

Ms. Lavine:

I see. That's been the past three or four

years or so?

Dr. Sherr:

I think so, yes.

Ms. Lavine:

Thank you. Now if I understand your testimony correctly, you weren't concerned with the billing rates so much as you were concerned with the appropriateness of the visit when you were reviewing the claims. Is that correct?

Dr. Sherr:

That's correct.

Ms. Lavine:

I don't think I have anything further at this point in time.

Mr. Schochet:

Mr. Jefsen.

Mr. Jefsen:

Not of Doctor Sherr at this time.

Mr. Schochet:

Alright, before I forget, may I have those three parts of Exhibit B. I read them into

the record but I didn't identify them in my notes.

Ms. Lavine:

Certainly. I would like to object to them on the grounds that they have not been published in the federal register pursuant to Title V of Section . . Title V United States Code Section 552.

Mr. Schochet:

Would you give me that code reference again.

Ms. Lavine:

Yes, Title V United States Code Section 552. That's the basic provision requiring publication.

Mr. Schochet:

We'll take that under consideration. It's on the record.

Ms. Lavine:

Thank you. Of course then my follow-up objection that those provisions are irrelevant to these proceedings and could not be considered to adversely .. could not be considered as

affecting Doctor Matanky adversly, as provided for in Title V Section . . .

Mr. Schochet:

Do you mean they could be considered at all? Or just not considered adversly?

Ms. Lavine:

The way I understand it the code section they could not affect Doctor Matanky at all.

Mr. Schochet:

So that's an absolute objection then.

Ms. Lavine:

Yes.

Mr. Schochet:

OK. What's next for the . . . I think we should have some explanation from the carriers representative you suggested that Mr. . . .

Mr. Jefsen:

Yes I think maybe so that everybody understands the procedure that is utilized in review, I'll let Mr. Molaison explain the summary in

general term exactly what happens to the claims after they have been reviewed by Doctor Sherr.

Mr. Molainson:

Mr. Jefsen, I'd like to go back a bit because Ms. Lavine keeps using alot of quotes from the Federal Regulations which and now she seems to want to feel that everything should be published in the Federal Register. Title XVIII of the Social Security Act, Section 1862 (a)(1) denies coverage for services that are not reasonable and necessary, and I'm really not prepared to give you the exact regulations and guidelines that they are under that spell out what carriers are supposed to do in applying this one provision of Title XVIII. But, from there Carriers are instructed to insure that payments are not made for services that are not reasonable and necessary, and in applying this, these regulations there, they are to establish various guidelines to use in

adjudicating claims. One of the other provisions says that services are to be paid in accordance with the general practice in the community and or the carrier is to use standards of the community in order to help determine what is reasonable and necessary. In applying that principle the carrier has established what we refer to as peer group norms, which are guidelines that we've developed indicating what we, what is considered normal in the community as to what is reasonable and necessary to expect a physician to bill. This is the basis for the PARE cases, excuse me, a little internal jargon, payment review project cases, which is what Doctor Matanky fell under originally. For exceeding the peer group norms, as established for nursing home visits, caused his claims to suspend, not to suspend, but caused his claims to be questioned as to the necessity for the services. I have some guidelines which were not published anywhere. Internal guidelines that were developed by Blue Shield

and these go back to December 15, 1966 and were from the then Chief Medical Advisor of Blue Shield as guidelines to be applied to nursing home visits. They stated, when the following conditions are mentioned the visits are to be paid as billed by the doctor without medical review; and basically with going through the 14 diagnoses given, they, they've referred to acute conditions, cardiac failure insufficiency, that type of thing. If you would like to look at them, I would be happy to let you look at them; but the basic idea is that any servere condition that would require the attention of the physician on more than once a month basis.

Doctor Matanky's claims did indicate these conditions, or conditions sufficient to justify the visits that were originally allowed. As Doctor Sherr pointed out when you look at them on a claim by claim basis, the necessity seemed to be there. It was only when you start comparing the practice to the peer group norm that you see

these and pull out a series of claims from months on end of service that the conditions, the diagnoses, repeat month after month acute, acute. You mentioned. . . are there any questions on that Mr. Schochet before I continue?

Mr. Schochet:

I have no questions.

Mr. Molaison:

You talked about the time limitations on re-openings and that as far as you could determine there was a, I may, I don't want to misquote you but there was nothing published before December 71 regarding going back three years prior, something to that effect. Again I don't have the specific references but I've read these regulations so many times I practically could quote them. The regulations entitled in the code of federal regulations, number V, there is a statement that reopening may be made at anytime under the circumstances of fraud or similar fault. Now the issue of

fraud was not used in adjudicating these claims, but remember the carriers are contracted by the Medicare Bureau to follow their instructions and their instructions are contained in the Medicare Carrier's Manual which I think we've referred to before, not in the hearing, but in correspondence. There is a section in the Medicare Carrier's Manual Section 121.00 which defines similar fault as a pattern of billing for, well I can't remember the exact quote, services that are not reasonable and necessary. Again as going back to the same point of the carriers operating under contract with the United States Government to do what the United States government tells us to do, we were instructed as the carrier by the Regional Office of the Bureau of Health Insurance of the Health Care Financing Administration of the HEW to do this review. And I have a letter which I think probably should be admitted into evidence. Mr. Schochet, May 1974 it's in the . . .

Mr. Schochet:

It is now admitted into the record as Exhibit C a photostatic copy of the May 1974 letter which purportedly directs the carrier involved to conduct this audit and review, is that correct.

Mr. Molaison:

Yes sir, that's correct

Mr. Schochet:

And copies have been furnished to the attorney for the claimant and the carrier's attorney.

Mr. Molaison:

I might point out for Ms. Lavine's information and clarification on the basis any misunderstanding that the current Medicare Bureau of the Health Care Financing Administration was at that time the Bureau of Health Insurance of the Social Security Administration, in case there has been any confusion.

Ms. Lavine:

Excuse me your honor, I object to this as

irrelevant. Doctor Matanky was given no notice of "unintelligable" as far as I can see.

Mr. Schochet:

It will be noted but it will probably be over ruled because I think that there is notice to Doctor Matanky early in the file of the early 70's of the review.

Mr. Jefsen:

I would also point out, if you want to follow it up with the next letter, there is reference to the fact that the Department of Health, Education and Welfare had previously notified Mr. Lavine of the action that they were telling the carrier not to undertake it, in the second paragraph in the letter. I'll see if I can locate a copy of that letter. And that letter to which I think that we have references a letter dated May 15, 1974 which is number 4 in the first volume that's been entered in the . . .

Ms. Lavine:

Say the page number.

Mr. Jefsen:

It's number 4, number 3 and 4.

Mr. Schochet:

Are you through Mr. Molaison?

Mr. Molaison:

I am.

Mr. Schochet:

Your question was as to the nature of the review?

Mr. Jefsen:

Right. What occurs with respect to the review as we process, as we move from completion of the medical advisor state into the stage of the computation actually in the dollars included.

Mr. Molaison:

The medical advisor, I think as Doctor Sherr has pointed out, strictly determines what procedures are reasonable and necessary, what RVS number should be used, how many treatments

to allow, so forth. It then goes to a clerical person who makes the calculations based on Medicare's reasonable charge criteria in effect at the time the services were rendered. And they do the calculating of how much money was allowed and should have been allowed and the recoupment that is done which is your file number 2.

Mr. Jefsen:

Just so that we understand all that Mr. Moliasen is saying, the method by which the dollar value is placed upon it is to pay that amount which is established by the practice within the community.

Mr. Molaison:

Well the level of care is determined according to the practice in the community and also the reasonable charges are developed according to the practice in the community. The doctor of course establishes his own customary charge for a particular service, but the prevailing

charge is then developed from the charges of all physicians in the same specialty in the area and the claims are paid of course of the lesser of the billed amount, the customary or the prevailing. I don't think there was any question in the carrier's mind as to the fees charged by Doctor Matanky on a peer service basis. I think we allowed $14.00 for a visit which is, that was in 69, so and then it went up to $20 I think. Doctor Sherr would you agree with that, that these fees were rather reasonable.

Dr. Sherr:

Well, in the area he is practicing in I think that they're fairly reasonable. My area they weren't, nevertheless they are in that area. Because we encourage the doctor to put down the usual and customary fee. The fee that he charges a private patient you see.

Mr. Jefsen:

I have no further questions Ms. Lavine.

Ms. Lavine:

Oh, Mr. Molaison

Mr. Schochet:

M O L A I S O N.

Ms. Lavine:

Oh that's right. I'm thinking of . . . french?

Mr. Schochet:

You're getting hungry.

Ms. Lavine:

Probably. That's a very acute medical diagnosis.

Mr. Schochet:

Medical - Legal.

Ms. Lavine:

I would like to direct your attention to the basis for reviewing the claims. I understood Mr. Jefsen to say that there was no dispute about whetherDoctor Matanky had actually made these visits and would agree with him for the purpose for this hearing, you were not contesting his actually having made the visits. Is that correct?

Mr. Molaison:

That's correct.

Ms. Lavine:

And so your disputes are on other lines. Is that correct? With Doctor Matanky over his billing.

Mr. Molaison:

We aren't questioning whether or not the services were actually rendered. We are questioning only whether or not there was medical necessity for the services rendered.

Ms. Lavine:

I see, and there is no, that's the only basis. It's not how much he charged.

Mr. Molaison:

Correct.

Ms. Lavine:

And are you the person who had some say after Doctor Sherr as to whether or not a visit was medically necessary?

Mr Jefsen:

I'm going to kind of object a little bit, because really, if I understand it correctly, medical decisions are made by medical people, and the question as to whether or not a visit is documented on the claim, and that's what we're talking about, I don't know, I don't particularly want to raise that question as to whether or not, quote, they're medically necessary. I'm saying the question presented to Doctor Sherr and you tell me, Doctor Sherr, to be sure I interpret you right, does the claim and information on the claim support the medical necessity of the services rendered, or the RVS number assigned to those medical services, and if it doesn't, then it has to be lowered or rejected. Is that correct?

Doctor Sherr:

That's correct and may I enlarge on it for just a second, because its important that we understand this. The claims of Doctor Matanky

were looked at and checked by a medical advisor who is a peer of Doctor Matanky's. Who has a practice almost identical to Doctor Matanky's for instance, an orthopedic surgeon wouldn't dare look at these claims, he wouldn't be allowed to, an ENT man wouldn't be allowed to. It's only one who is one of your peers because you are judged by the peer group normal, as was brought up earlier.

Ms. Lavine:

You are the peer, right?

Dr. Sherr:

That's correct. So consequently we have a number of general practitioners, in a similar type of practice, who did and do have patients in sanitariums, hospitals and all sorts of private calls. And it is that kind of a practitioner that is allowed to review those claims.

Ms. Lavine:

I see. You are the peer who was reviewing

the claims involved in this hearing.

Dr. Sherr:

I think that I did most of the reviews.

Ms. Lavine:

So it was your say so as to whether or not a visit was medically necessary. Is that correct?

Dr. Sherr:

Whether it was medically necessary and fitted the guidelines that were given to us.

Ms. Lavine:

I see.

Dr. Sherr:

Medicare Medi-Cal.

Ms. Lavine:

And then, Mr. Molaison, your only testifying to the procedure that was used in Blue Shield to process these claims. Is that correct?

Mr. Molaison:

Correct.

Ms. Lavine:

Your in effect saying to me that Blue Shield didn't follow any time limits on review. Is that correct?

Mr. Molaison:

We followed the time limit that the Medicare Bureau instructed us to follow, which was go back to and review all the claims from 1966 to the present, which was then 1974. We didn't go all the way back to 1966 because we were not able to obtain the records. In fact the bulk of the claims did not go that, well, it started in 1967 and then we went forward from there to 1973, I believe it was.

Ms. Lavine:

So what your saying is you didn't follow any particular regulations published in the federal register but just for what you were told to do through interoffice memorandums or whatever. Is that correct?

Mr. Molaison:

Regulations as to each and every coverage issue determination are not published in the federal register. It would be a sheer impossibility. These are regulations and guidelines that are established by the, well, the guidelines were established by the carrier for services prior to January 1, 1971 and the guidelines prior to that were by the carrier; subsequent to that were Medicare regulations which had been issued.

Ms. Lavine:

So what your saying is that you followed some kind of guidelines and a some kind of communication from the Social Security Administration asking you to review claims in which payments had already been made. Is that correct?

Mr. Molaison:

Correct.

Mr. Jefsen:

Let me back up, had payments been made in '71. I guess they had been up through that period of time. Your right. . .OK

Mr. Schochet:

I think the right word is they're directing review, not requesting. Because there was not any initiative on the part of the carrier, it was ordered by the central and national authority.

Ms. Lavine:

As I understand it, correct me, did the Social Security Administration notify any patient that a review of his claims would occur after payment had been made?

Mr. Molaison:

Just the ones that they audited as . . . and contacted as part of the indictment. As far as I know.

Ms. Lavine:

Is it your position that these people were

actually contacted?

Mr. Molaison:

The information given to us says they were.

Ms. Lavine:

Well I'd like to make a statement at this time. I interviewed many of those people personally but. . . and the people for the most part indicated to me that they had no knowledge . . .

Mr. Schochet:

What people?

Ms. Lavine:

The people involved in the indictment.

Mr. Schochet:

Now just a minute I think we should establish there were those people billing Medicare directly or was the billing done by the doctor?

Ms. Lavine:

I believe the billing was being done by the doctor. Is that correct?

Dr. Matanky:

Thats correct.

Mr. Schochet:

Then your talking about the patient beneficiaries where they were notified when the billing was from the doctor and normally as I understand the practice is for the carrier to notify only the doctor. Is that right?

Mr. Jefsen:

Yes and I may be wrong and I'll stand subject to correction, especially going back in that period of time. As I understand it, if a doctor accepts a Medicare patient and accepts the assignment . . .

Mr. Schochet:

These were not assigned claims were they?

Dr. Matanky:

Yes.

Mr. Schochet:

They were?

Dr. Matanky:

Yes.

Mr. Schochet:

I thought they were not.

Mr. Jefsen:

Oh yes, he accepts the assigned claim and takes them as an assignment, that the beneficiary then has nothing to do with it.

Dr. Sherr:

However, Medicare generally lets the beneficiary know.

Mr. Jefsen:

Yes, that's true.

Dr. Sherr:

This is not a bill. Because that tells them what the transaction was and how much was paid to the physician.

Mr. Jefsen:

Yes.

Mr. Schochet:

And again normally on a case like that, that

does not mean any liability on the part of the patient if the doctor accepts assignment. He accepts assignment as whatever he gets as payment in full subject to further deduction over the usual 20% for deductibles for co-insurance. Is that correct?

Mr. Jefsen:

That's my understanding.

Dr. Sherr:

I might say as a physician I personally would object to several dozen patients being notified that claims are being reevaluated checked and so on. I kind of would be disturbed about that. They'd wonder what's going on. What am I doing.

Dr. Matanky:

If I can answer this as an ongoing thing, with me continuously and these, in this particular audit none of these patients were notified. And if I am correct, a visit that is not allowed by Medicare then according to

your rules and regulations I can then go and bill that patient for that visit.

Mr. Schochet:

For services not covered.

Dr. Matanky:

For services, but when a visit is not covered. See they have the right to reduce the amount of money that they feel should be paid but then when they completely eliminat a visit, then like when they go from four visits to two visits. Then those two visits that are completely eliminated according to their own rules and regulations, I am allowed to bill that patient for that service. So therefore, the beneficiary is really very much involved because if there are visits that are not allowed, then that beneficiary is responsible for those and I can bill that patient.

Mr. Schochet:

Without being final about it I would question that as an absolute statement, Doctor Matanky.

For example, supposing there has been surgery and you have a so called global fee and there is a consultation that was billed but or a later visit which is included in the global fee but the doctor has billed for it. That is not a covered service and he would have no way to collect for that.

Dr. Matanky:

Well your talking about surgery, I'm talking about medical.

Mr. Schochet:

I'm talking about cases I've heard.

Dr. Matanky:

Ok but medical visits.

Mr. Schochet:

I don't like flat rules.

Dr. Matanky:

Ok I understand, but this is what I have been informed and correct me if I am wrong, and that would have to be according to their own rules and regulations, and this is what is

being promulgated by instruction to my personnel, and Carmen is the one who specifically said that, she came from UCLA, got an 'A' in her course and was told that specific fact.

Mr. Jefsen:

I think that in part your right and in part your wrong and where you have the difficulty is exactly the example that you gave quote "What is a covered service." If you render a service which is not a covered service, and then you erroneously somehow bill Medicare for and the bill comes back and is not paid, that's fine. I have a real question in my own mind that if your treating a patient, for an ongoing geriatric problem at a convalescent home or at an extended care facility home, that that whole course of treatment is "A covered service" and if you over-utilize or can't justify the utilization above and beyond the guidelines, quote, they're going to treat that whole period of interment as a covered

service and not allow you to bill for the one visit we didn't pay.

Dr. Matanky:

That is incorrect. Now I would suggest that you look at your own rules for any . . .

Mr. Schochet:

Ok gentlemen let's stop it right then and there. There is a difference of opinion, it's not pertinent right here. I think your both under the moral duty to look it up and clear your own minds on it and if you can, clear mine too.

Dr. Sherr:

It is considered, by most doctors, that if the guidelines say that one visit per month on a chronic patient is sufficient, then the other services, the other visits are not considered pertinent and payable visits. On the other hand if it is documented, the patient has a very serious or acute problem whatever the reason is that you really have to go there,

that is a payable service.

Dr. Matanky:

Well that is not the point that I'm bringing up.

Mr. Schochet:

He is talking about being able to collect on the side legitimately from his patients.

Dr. Sherr:

Well they are not payable visits according to . . .

Mr. Schochet:

Ok there is a difference in opinion that is not pertinent here, so lets drop it and continue.

Ms. Lavine:

Now wait a minute, Doctor Matanky.

Dr. Matanky:

Ok.

Ms. Lavine:

He's made a ruling.

Mr. Schochet:

You have a question for Mr. Molaison?

Ms. Lavine:

Yes. Mr. Molaison I have one other question to ask you. Were the patients concerning whose claims were coming in after the point in 1971 when no payment was being made to Doctor Matanky. What kind of notice was given to those patients concerning payment to Doctor Matanky?

Mr. Molaison:

I really don't know exactly what the notification would have said.

Ms. Lavine:

Well, were they notified that he had actually been paid?

Mr. Molaison:

As I said I don't.

Ms. Lavine:

You don't know at all?

Mr. Molaison:

I don't know. I would have to check with some . . .

Ms. Lavine:

You have any means of records, of record keeping?

Mr. Molaison:

I'm sure I could check with some of our internal people who deal in this matter directly and find out . . .

Mr. Schochet:

I think I for sure answered that a few minutes ago. Saying that in many cases where the payment goes right to the doctor and Doctor Matanky is nodding his head, yes. The patient gets a copy of the staement forwarding the amount paid by Medicare to the attending physician but across of the stamp in big visable letters is this is not a bill. And it shows the amount billed by the doctor, the amount considered by Meeicare less the deduction and the net amount at the bottom of this page. So I think that would answer that question although not by Mr. Molaison.

Ms. Lavine:

Well, my problem is that of course after 1971 for a quite period of time Doctor Matanky was given no payments at all. My question was meant to inquire about what kind of notice was given to those patients about whether payment had been made or whether it was being withheld. The reason I ask this, your honor, is that I think those people were entitled to know whether or not their medical services were being paid for and if they weren't being paid for, then they had a right to know that in order to make other arrangements.

Mr. Schochet:

Even if the claims were assigned?

Ms. Lavine:

I think so.

Mr. Schochet:

And you testified I believe or stated earlier, not testified, stated earlier that you had

consulted a number of patients yourself had you?

Ms. Lavine:

May I make a complete statement on that. I really wasn't complete on that.

Mr. Schochet:

I understood you to indicate that you had consulted a number of patients and that you received information from them.

Ms. Lavine:

Yes. Not in this, these claims were involved in this hearing. It was on the . . .

Mr. Schochet:

It was on another case?

Ms. Lavine:

On the claims that were not involved in this, because . . .

Mr. Schochet:

Well then the whole thing was irrelevant and what you said was improperly stated and put into this record.

Ms. Lavine:

Well it was in response to matters discussed by other counsel.

Mr. Schochet:

Well, that's why I try to keep things pertinent. Go ahead.

Ms. lavine:

I appreciate that. That's not . . .

Mr. Schochet:

See it's a misleading statement because otherwise somebody would think that you interviewed these patients involved here. That's what we're here for today.

Ms. Lavine:

I appreciate that but I was responding to what Mr. Molaison was talking about.

Mr. Schochet:

Was that your last question for Mr. Molaison?

Ms. Lavine:

For right now it is, yes.

Mr. Schochet:

Do you have anything else Mr. Jefsen?

Mr. Jefsen:

I have, I'd only offer one more letter of December 9th again just so the whole matter is before this hearing and I think that may already be a part of your file though I couldn't find it in my duplication and it's just a letter of December 9, 1969, again to the doctor, by one of the medical advisors of Blue Shield indicating that at that time the one visit per month rule was, in essence, the one visit per month guideline was applicable.

Mr. Schochet:

This will now be admitted as Exhibits D, being as stated by Mr. Jefsen, a photostatic copy of a December 9, 1969 letter to Doctor Matanky from Doctor Riley a Blue Shield Medical Advisor. I don't recall if that is in the file or not, we'll check that later. If not then we can have a copy made.

Ms. Lavine:

I would appreciate that because I don't believe it is in the compilation that we received so far. I would object this on the grounds of irrelevancy because it does not appear to limit, apply to Medicare but appears to apply to Medi-Cal matters which are beyond the scope of these proceedings.

Mr. Schochet:

May I ask aren't a great many of these claims Medi Medi?

Mr. Jefsen:

A great number of the claims are combinations back and forth and my purpose, the scope of my purpose, in putting the letter into evidence is again to show that we're not talking, what I think of, as a lawyer as a hard fast rule and regulation. We're talking really about guidelines trying to help providers under the program to have some means as to what quote will be utilized to determine what is medically

necessary and what is not. And if an applicable of Medi-Cal is basically going to be along the same lines as Medicare if it's "medically necessary" under one, certainly it is going to be medically necessary under the other and if it is questionable under one it might be questionable under the other.

Mr. Schochet:

Alright who is next with something should be on the record?

Ms. Lavine:

Of course, your honor, we do object to and oppose the statements that Mr. Jefsen has just made concerning . . .

Mr. Schochet:

I'd assumed that.

Ms. Lavine:

Thank you.

Mr. Jefsen:

I have nothing further your honor.

Mr. Schochet:

Do you have anything Mr. Molaison?

Mr. Molaison:

No, I cant' think of anything.

Mr. Schochet:

Doctor Sherr is there anything else that you could contribute to this material that we should know?

Dr. Sherr:

No, not with regard to these claims.

Mr. Schochet:

Well that's what your here for and now Ms. Lavine you have with your father a great many rather somewhat numerous letters in the file containing some ominous sounding common and legal arguments about due process, deprivation of property, right to property, lack of notice lack of publication and according satisfaction which you quoted California Law and so on. Do you want to send us a written summary on it. The reason I suggest written

summaries in cases of they type, is that from my own fairly extensive experience as a lawyer you can think of something now and then on the way home, bingo you left something out. So I would rather have somebody grab something and then look it over the next day or even a third day and then feel that they've got it pretty well wrapped up and then send it in and call it quits on that deal because we can't keep it open any longer you know that.

Ms. Lavine:

I agree with you. I think that would be most advisable. You've asked me about certain copies of matters here that I hope will be much more helpful to you if I have them here or have them as an argument and we would like you to do a little research and give you this citation of Goldberg vs Kelley and discuss the various . . .

Mr. Schochet:

Well I'll find that out. I just thought you had it handy. Lord knows I've discussed Goldberg vs Kelley numerous times within the last what was it about of the earlier '70s wasn't it. Anyway it was quoted extensively and I remember the disability cases too. But with what you have in the file, with what you've put in the record today, I would think that you should be able to send it to us in a week.

Ms. Lavine:

That's fine. Now where shall I send it to?

Mr. Schochet:

Well after your sending, nature takes its course it goes in different directions depending where I am at the time. So you send it to the San Francisco office and its called to my attention. Mr. Jefsen would you like the same privilege?

Mr. Jefsen:

Alright, I will take a look. I'm not sure that a response will be necessary. We've already covered on that say, we've talked about it; but I will take a look and get back to you in about a week.

Mr. Schochet:

I want you to have the same opportunity. As you understand, I'm impartial, I am on a contract to do exactly what I think is right, which isn't necessarily for one side or for the other and that's my practice. I'll ask again does anybody have anything else to put into the record that they think is pertinent that has not been put in already, and of course it is assumed that all the laws, rules and regulations are part of the file by virtue of their nature. If you have anymore references, please put thim in now. I notice that some of the libraries in the city are not complete, for example, UCLA Library does not

have the CCH on the Medicare, Medica. . . Well on that note and I assume to the surprise of everyone present, the hearing is being closed at 11:50 a.m., this 7th day of August, 1978. Now there will be time of course allowed for receiving the briefs, after that I do not know, this is not such a simple matter, for some of these cases it is very simple, but now we have to be sure that the rules are as they are alleged by the carrier, and some have been questioned and denied . . . on behalf of the claimant . . . The research is going to be an arduous task at least so far as I'm concerned; but as soon as it can be done, a decision will be issued and copies will be sent to both parties and I thank you all for bein here this morning. I am glad that we were finally able to get together and I hope that you have everything in the record now, and please take all of those big boxes with records out of the room and let me see them no more. On that note the hearing is closed. Thank you.

20 CFR, Part 405 as published in the Federal Register, Volume 37, No. 2, January 5, 1972, pages 89-91

Social Security Administration

[20 CFR Part 405]

(Reg.No.5]

FEDERAL HEALTH INSURANCE FOR THE AGED

Provider Review Procedures and Suspension of Payments Under Medicare

Notice is hereby given, pursuant to the Administrative Procedure Act (5 U.S.C. 552 et seq.) that the amendments to the regulations set forth in tentative form below are proposed by the Commissioner of Social Security, with the approval of the Secretary of Health, Education, and Welfare. The proposed amendments (1) require intermediaries to institute review procedures for providers dissatisfied intermediaries' determinations on cost reports; and (2) provide that payments to providers and

suppliers of services could be suspended to recover overpayments to them only after such providers and suppliers have been afforded an opportunity to present evidence on the issue of the overpayment, and where a suspension of payments is put into effect there would be an expeditious settlement of the issues involved. It is intended that regulations dealing with provider reviews be effective for cost reporting periods ending on or after December 31, 1971, and that the regulations on suspensions be effective January 1, 1972.

* * *

The proposed regulations are to be issued under the authority contained in sections 1102, 1815, and 1871, 49 Stat. 647, as amended, 79 Stat. 296, 322, and 331, as amended; 42 U.S.C. 1302, 1395 et seq.

Dated: December 2, 1971.

Robert M. Ball
Commissioner of Social Security

Approved: December 29, 1971.

ELLIOT L. RICHARDSON,
Secretary of Health, Education,
and Welfare.

Regulation No. 5 of the Social Security Administration (20 CFR Part 405) is further amended as follows:

1. The heading to Subpart C is revised to read as follows: Subpart C--Exclusions, Recovery of Overpayment, Liability of a Certifying Officer, and Suspension of Payment.

2. Section 405.301 is revised to read as follows:

§ 405.301 Scope of subpart.

Sections 405.310 to 405.320 describe certain exclusions from coverage applicable to hospital insurance benefits (part A of Title XVIII) and supplementary medical insurance benefits (part B of title XVIII). The exclusions in this subpart are applicable in addition to any other conditions and limitations in this part 405 and in title XVIII of the Act. Sections 405.350 to 405.359

relate to the adjustment or recovery of an incorrect payment, or a payment made under section 1814(c) of the Health Insurance for the Aged Act. Sections 405.370 to 405.373 relate to the suspension of payments to a provider of services or other supplier of services where there is evidence that such provider or supplier has been or may have been overpaid.

3. New §§ 405.370-405.373 are added to read as follows:

§ 405.370 Suspension of payments to providers of services and other suppliers of services.

(a) Payments otherwise authorized to be made to providers of services and other suppliers of services in accordance with subpart A or subpart B of this part 405 (but excluding payments to entitled individuals and payments under § 405.251 (a) may be suspended, in whole or in part, by an intermediary or a carrier when:

(1) The intermediary or carrier has determined that the provider or other supplier to whom such payments are to be made has been overpaid under the XVIII of the Social Security Act, or

(2) The intermediary or carrier has some evidence, although additional evidence may be needed for a determination, that such overpayment exists or that the payments to be made may not be correct.

(b) A suspension shall be put into effect only after the provisions in §§ 405.371 and 405.372 have been complied with and the intermediary or carrier has determined that the suspension of payments, in whole or in part, is needed to protect the program against financial loss. The provisions of this section and §§ 405.371-405.373 shall be effective on January 1, 1972.

§ 405.371 Proceeding for suspension.

(a) General. Whenever the intermediary

or carrier has determined that a suspension of payments under § 405.370 should be put into effect with respect to a provider of services or other supplier of services, the intermediary or carrier shall notify the provider or other supplier of its intention to suspend payments, in whole or in part, and the reasons for making such suspension. The provider or other supplier will be given the opportunity to submit any statement (including any pertinent evidence) as to why the suspension shall not be put into effect and shall have 15 days following the date of notification to submit such statement, unless the intermediary or carrier for good cause imposes a shorter period. The intermediary or carrier may, for good cause shown, extend the time within which the statement may be submitted. If no statement is received within the 15-day period or such other period as specified in the notice, the suspension shall go into effect.

(b) Fraud or misrepresentation. The provisions of paragraph (a) of this section shall not apply where the intermediary or carrier has reason to believe that the circumstances giving rise to the need for a suspension of payments involves fraud or willful misrepresentation. Instead, the intermediary or carrier may suspend payments without first notifying the provider or other supplier of an intention to suspend payments. The provider or other supplier will be notified of such suspension and the reasons for taking such action.

(c) Notice of amount of program reimbursement. The provisions of paragraph (a) of this section shall not apply where the intermediary, after furnishing a provider a written notice of the amount of program reimbursement pursuant to § 405.491, suspends payment under paragraph (b) of such § 405.491.

* * *

§ 405.372 Submission of evidence and notification of administrative determination to suspend.

When pursuant to § 405.371(a) the provider or other supplier submits a statement, the intermediary or carrier shall consider such statement (including any pertinent evidence submitted), together with any other material bearing upon the case, and make a determination as to whether the facts justify a suspension authorized by § 405.373. If the intermediary or carrier determines that a suspension should go into effect, written notice of such determination will be sent to the provider or other supplier. Such notice will contain specific findings on the conditions upon which the suspension was based, and an explanatory statement for the final decision.

§405. 373 Subsequent action by intermediary or carrier.

(a) Where a suspension is put into effect

by reason of § 405.370(a), such suspension shall remain in effect until (1) The overpayment is liquidated, (2) the intermediary or carrier enters into an agreement with the provider or other supplier for liquidation of the overpayment, or (3) the intermediary or carrier, on the basis of subsequently acquired evidence or otherwise, determines that there is no overpayment; except that the intermediary or carrier may at any time adjust such suspension for an appropriate period if it determines that continuation of the suspension would cause irreparable harm to the provider or other supplier.

(b) Where the suspension is put into effect by reason of § 405.370(b), the intermediary or carrier will take timely action after such suspension to obtain such additional evidence it may need to make a determination as to whether an overpayment exists or the payments may be made (i.e., evidence from the records of the provider or other supplier of services).

All reasonable efforts will be made by the intermediary or carrier to expedite such determinations. As soon as such determination is made, the provider or other supplier will be informed and, where appropriate such suspension will be rescinded or adjusted to take into account such determination. If such suspension is not rescinded, it shall remain in effect as specified in paragraph (a) of this section.

(c) The provisions of this section shall not apply where the intermediary or carrier, in suspending payments pursuant to § 405.370, had reason to believe that the circumstances giving rise to such suspension involve fraud or serious misrepresentation.

No. 82-1217

In the Supreme Court of the United States

OCTOBER TERM, 1982

SEYMOUR R. MATANKY, M.D., ET AL., PETITIONERS

v.

UNITED STATES OF AMERICA, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

REX E. LEE
Solicitor General

J. PAUL MCGRATH
Assistant Attorney General

NICHOLAS S. ZEPPOS
Attorney

Department of Justice
Washington, D. C. 20530
(202) 633-2217

QUESTION PRESENTED

Whether the Court of Claims correctly dismissed petitioner's suit seeking to recover on claims under Part B of the Medicare Program, 42 U.S.C. 1395 *et seq.*

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases:

Page

Cases—Continued:

Constitution, statutes and regulations:

Page

Constitution, statutes and regulations—Continued:

Miscellaneous:

In the Supreme Court of the United States

OCTOBER TERM, 1982

No. 82-1217

SEYMOUR R. MATANKY, M.D., ET AL., PETITIONERS

v.

UNITED STATES OF AMERICA, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

BRIEF FOR THE RESPONDENTS IN OPPOSITION

OPINIONS BELOW

The order of the Court of Claims dismissing the complaint (Pet. App. D-1 to D-3) is unreported.

JURISDICTION

The judgment of the Court of Claims was entered on September 17, 1982 (Pet. App. D-1), and a petition for rehearing was denied on October 22, 1982 (Pet. App. F-1). The petition for a writ of certiorari was filed on January 20, 1983. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATEMENT

1.a. Petitoner Matanky is a physician who provided medical care to individuals insured under Part B of the Medicare Program, 42 U.S.C. (& Supp. IV) 1395 *et seq.*

(Pet. 13).[1] The medical services principally at issue here are visits to patients in nursing homes. The claims of petitioner's patients for reimbursement under Medicare were assigned to petitioner, who then submitted the claims to and received payment from Blue Shield of California. Blue Shield performed the task of evaluating and paying such claims pursuant to a contract with the Secretary of Health and Human Services. 42 U.S.C. (& Supp. IV) 1395u; see *Schweiker* v. *McClure*, 456 U.S. 188, 190-191 (1982). Blue Shield was required by regulations to "[i]nstitute utilization safeguards which include methods for professionally assuring that payments under Part B * * * are for services which are medically necessary" and to take "appropriate action with respect to adjustment or rejection" of a claim for services that were not medically necessary. 20 C.F.R. 405.678(c) (1969); 42 U.S.C. 1395y(a)(1); see *Drennan* v. *Harris*, 606 F.2d 846, 848 (9th Cir. 1970).

In June 1971, petitioner was notified by Blue Shield that the Social Security Administration had requested that future Medicare reimbursements to petitioner be withheld pending an investigation into possible irregularities in the submission of his claims (see Pet. 13-14). In April 1972, a federal grand jury in the Central District of California returned a 46-count indictment charging petitioner with defrauding the United States, in violation of 18 U.S.C. 1001, by submitting false claims to Medicare carriers for visits to patients in nursing homes that he had not made. See *United States* v. *Matanky*, 482 F.2d 1319, 1321 (9th Cir. 1973).

---

[1] Petitioner Matanky owns and operates the Corbin Medical Clinic (Pet. App. A-2), which also is a petitioner in this case. The references in the text to "petitioner" are to petitioner Matanky.

Following a three-week trial in October 1972, petitioner was convicted on 39 of the counts in the indictment, the remaining counts having been dismissed on the government's motion (482 F.2d at 1321, 1323). He was sentenced to concurrent three-year terms of imprisonment on each count, execution of which was suspended in favor of one year's probation, and was fined $1,500 on each count, for a total fine of $58,500 (*id.* at 1321; Pet. at 2, *Matanky* v. *United States*, No. 73-334 (1973 Term). The court of appeals affirmed the convictions (482 F.2d at 1321), noting that although petitioner claimed to have visited certain patients two or more times per week, the patients and nursing personnel testified that the visits occurred only once or twice per month (*id.* at 1323). This Court denied certiorari. 414 U.S. 1039 (1973). The government's civil claims against petitioner in connection with the 46 incidents involved in the indictment were settled by agreement with petitioner in the spring of 1974 (R. 131).[2]

b. After matters related to these 46 claims were resolved, the Social Security Administration requested Blue Shield to review other claims submitted by petitioner for visits to patients in nursing homes (R. 131-132). Following an audit of Medicare Part B claims filed by petitioner between 1967 and 1973, Blue Shield determined in August 1975 that petitioner had been overpaid in the amount of $51,316.14 for 2412 claims for services provided to 305 beneficiaries that had not been shown to be medically necessary. Some $1,634.72 in excess of that amount that had been withheld from petitioner was paid to him at that time (Pet. App. A-19; R. 187). On January 22, 1976, petitioner requested that Blue Shield conduct an administrative review of this initial decision—the next stage in the carrier appeals process (R. 190; see *Schweiker* v. *McClure*, *supra*, 456 U.S. at

---

[2]"R." refers to the administrative record.

191). On September 30, 1976, after "extensive evaluation" (R. 187), the initial decision regarding the extent of overpayments was affirmed by Blue Shield, with a minor adjustment resulting in the payment of an additional $425 to petitioner (R. 187-189). Four months later, on January 28, 1977, petitioner filed a request for an oral evidentiary hearing by the carrier regarding the remaining claims (R. 183). That hearing was held on August 7, 1978 (Pet. App. G-1), after several postponements.[3]

c. The attorney for Blue Shield stated at the hearing that Blue Shield was not questioning at that time whether petitioner actually made the nursing home visits in question, although the hearing officer reserved the right to question that fact. The sole question to be considered at the hearing was the medical necessity for the visits (Pet. App. G-37 to G-38). Although petitioner testified at the hearing (*id.* at G-30 to G-55), he did not furnish evidence specifically relating to the need for any of the nursing home visits that Blue Shield had determined not to have been medically necessary. Instead, he testified only to his general view that his practice of making two or more visits per week to patients in nursing homes was appropriate (*id.* at G-31 to G-35). Petitioner also testified that he was not aware of certain requirements regarding documentation for nursing home visits because he had left those matters to his office manager (*id.* at G-43, G-51 to G-54).

---

[3]The hearing officer informed petitioner that because of the complexity of the case, the hearing would not be scheduled until mid-summer of 1977 (R. 181). The hearing subsequently was set for July 13, 1977 (R. 180), but was rescheduled for August 22, 1977, at petitioner's request (R. 179). Petitioner then sought and was granted a further postponement (R. 173, 174). During this time, petitioner engaged in discovery and apparently suggested settlement of the dispute (R. 169-172). Finally, in response to a suggestion by the hearing officer that the case had been pending "far too long" (R. 159), petitioner requested that the matter be taken off the calendar (R. 157). In April 1978, he requested that another hearing date be set (R. 155), and the hearing then was scheduled for August 7, 1978 (R. 154).

Another witness explained that carriers—when determining what services are medically necessary in the absence of regulations and instructions from HHS—apply the standards of the physician's peers in the community, and that petitioner's claims, when reviewed over a period of time, deviated from those norms (Pet. App. G-86 to G-88). The physician who had conducted the audit of the claims in question testified that there was inadequate documentation in many cases that the nursing home visits were medically necessary (*id.* at G-67 to G-68, G-98 to G-99), especially because the same diagnosis often was repeated for visit after visit without elaboration (*id.* at G-47, G-72; see also *id.* at G-88 to G-89). A representative of Blue Shield explained that Medicare policy reflected in formal guidelines issued in 1970 and 1971 did not bar reimbursement for more than one nursing home visit per month, but required only that an explanation be provided to support the medical necessity of more than one such visit (*id.* at G-75).

d. In October 1978, the hearing officer issued a decision holding that petitioner had been overpaid in the amount of approximately $50,518.22 for uncovered services, and ordered the refund of an additional $371.60 to petitioner (Pet. App. A-26). The hearing officer explained that although petitioner had furnished general information and opinion regarding some details of his practice, he had furnished "no additional information referring to specific claims as required by Medicare ground rules, policies and regulations" (*id.* at A-24 to A-25).

2.a. Petitioner filed an action in the United States District Court for the Central District of California on December 21, 1978, seeking judicial review of the carrier's decision (Pet. App. A-1 to A-14). He asserted that the district court had jurisdiction over his Medicare Part B claims under 42 U.S.C. (Supp. IV) 405(g) (Pet. App. A-2, A-14), even though 42 U.S.C. 1395ff(b) provides for judicial

review of reimbursement claims pursuant to 42 U.S.C. (Supp. IV) 405(g) only under Part A of the Medicare Program. See *United States* v. *Erika, Inc.*, 456 U.S. 201, 207 (1982). The district court transferred the case to the Court of Claims (Pet. 16), in accordance with the prior decision of the United States Court of Appeals for the Ninth Circuit in *Drennan* v. *Harris, supra.*[4] In *Drennan*, the Ninth Circuit had concluded that the district court did not have jurisdiction over Part B claims under either the Medicare Act (42 U.S.C. 405(g)) or 28 U.S.C. 1331, but ordered a transfer of the case to the Court of Claims because that court had ruled in *Whitecliff, Inc.* v. *United States*, 536 F.2d 347 (1976), cert. denied, 430 U.S. 969 (1977), that it had jurisdiction over Medicare cases under the Tucker Act if judicial review was not available elsewhere. 606 F.2d at 849-850.

b. The Court of Claims stayed proceedings in this and a number of similar cases pending this Court's decision in *United States* v. *Erika, Inc., supra*, which presented the question whether the Court of Claims had jurisdiction under the Tucker Act over an action seeking reimbursement for claims under Part B of the Medicare Act. After this Court rendered its decision in *Erika* holding that Congress had foreclosed judicial review of a carrier's determination of the amount, if any, of reimbursement due on a Part B claim, the Court of Claims dismissed petitioner's complaint (Pet. App. D-1 to D-3). The court reasoned that petitioner's challenge to the amount of reimbursement was barred by the decision in *Erika*, and, further, that petitioner's constitutional claims were insubstantial and thus furnished no

---

[4] *Drennan* involved a similar reduction by the carrier, after a peer review, in the number of reimbursable monthly visits between 1969 and 1971 by a physician to patients in nursing homes where there was no documentation to establish that more than one visit per month was medically necessary (606 F.2d at 848).

basis for avoiding the jurisdictional holding in *Erika* (*ibid.*).[5]

ARGUMENT

1. This Court held in *United States* v. *Erika, Inc.*, 456 U.S. 201 (1982), that there is no right to judicial review of benefit determinations under Part B of the Medicare Act and that the Court of Claims therefore was without jurisdiction to entertain such a suit. Accordingly, the Court of Claims correctly dismissed this suit for lack of jurisdiction on the authority of *Erika*.

Petitioner seeks to avoid the holding in *Erika* by contending that this case involves constitutional issues and that Congress did not and could not foreclose all judicial review of constitutional questions. Specifically, petitioner alleged in his complaint that Blue Shield violated the Due Process Clause in several respects in its consideration and decision on the reimbursement claims and in its recoupment of the amounts erroneously paid. It is well settled, however, that the Court of Claims does not have jurisdiction under the Tucker Act over an action seeking a monetary recovery for a violation of the Due Process Clause, because that Clause cannot be read to mandate monetary compensation for a violation. See *United States* v. *Hopkins*, 427 U.S. 123, 130 (1976); *United States* v. *Testan*, 424 U.S. 392, 400 (1976). The Court of Claims has specifically so held in the Medicare

---

[5]The Court of Claims disposed of petitioner's case in summary fashion, citing to other orders of that court in cases raising similar issues (see Pet. App. D-2). An examination of these other orders makes clear the basis for the Court of Claims' disposition of this case. The Court of Claims also declined to transfer the case back to the District Court for the Central District of of California, in view of the insubstantiality of petitioner's constitutional claims and the Ninth Circuit's decision in *Drennan* v. *Harris, supra*, that district courts do not have jurisdiction over such claims (Pet. App. D-3, citing *Berton Siegel* v. *United States*, No. 119-81C (Ct. Cl. Aug. 20,1982)).

context. *Alabama Hospital Ass'n* v. *United States*, 656 F.2d 606, 609-610 (1981), cert. denied, 456 U.S. 943 (1982); *Regents of the University of Colorado* v. *United States*, No. 518-80C (Ct. Cl. Aug. 27, 1982), slip op. 3-4. Therefore, because jurisdiction over petitioner's statutory claim for reimbursement under Part B was barred, the appending thereto of arguments arising under the Due Process Clause could not serve to vest the Court of Claims with jurisdiction.

2. In any event, as the Court of Claims held, the constitutional claims set forth in petitioner's complaint clearly are insubstantial, especially in the context of this case (Pet. App. D-2). The Court of Claims correctly determined that such wholly insubstantial constitutional claims cannot avoid the jurisdictional holding in *Erika*.

a. As an initial matter, although petitioner framed several of the paragraphs in his complaint in constitutional terms, at bottom his principal contention is simply that the Secretary did not have statutory authority to offset the amount of payments erroneously paid on past claims against the amount that would be due on different, currently pending claims. See Pet. App. A-6 (para. VII), A-8 to A-9 (para. XIII), A-10 to A-11 (paras. XV-XVII), A-12 (paras. XVIII(l) and (3)). This question is one of statutory interpretation, not constitutional right, because it is clear that the Constitution does not bar an agency from recovering, by means of offset, public funds that were improperly paid or expended. See, *e.g. United States* v. *Munsey Trust Co.*, 332 U.S. 234, 239-240 (1947); see generally Brief for the Petitioner, at 15-17, *Bell* v. *New Jersey*, No. 81-2125 (argued Apr. 18, 1983).[6] Thus under *Erika*, the Court of Claims had no jurisdiction to review the carrier's adjustment of the Part B reimbursement claims at issue here.

---

[6]We have furnished counsel for petitioner with a copy of the Brief for Petitioner in *Bell* v. *New Jersey*.

Moreover, the right of HHS, through intermediaries and carriers, to exercise the common law right of recoupment by offsetting amounts erroneously paid for services found not to have been covered by Medicare is well established. See *Mt. Sinai Hospital* v. *Weinberger*, 517 F.2d 329 (5th Cir. 1975), cert. denied, 425 U.S. 935 (1976); *Szekely* v. *Florida Medical Ass'n*, 517 F.2d 345 (5th Cir. 1975). As the Fifth Circuit noted in *Szekely* (517 F.2d at 349), the Medicare Act itself, as amended in 1972, expressly recognizes the right to recover funds previously paid to a physician, such as petitioner, who has furnished services and accepted an assignment of a claim from an individual covered by Part B. In 42 U.S.C. 1395u(b)(3)(B)(ii), Congress prohibited a physician from collecting from his patients for services found not to have been covered by Medicare "if the Secretary's determination that payment (pursuant to such assignment) was incorrect * * * was made subsequent to the third year following the year in which notice of such payment was sent to such individual." 42 U.S.C. 1395u(b)(3)(B)(ii); see also 42 U.S.C. 1395cc(a)(1)(B). This provision plainly contemplates that payments that were "incorrect" because the services were not covered by Medicare may be recovered from the physician, even more than three years after they were made.[7] In addition, 42 U.S.C. 1395gg(b)(l)(A) in turn recognizes that excess payments may be recouped from a person who has furnished services under Part A or Part B.

---

[7]Given this express statutory ratification of the right of a carrier to recover from a physician on an assigned claim more than three years after payment was made, petitioner's contention in the complaint (Pet. App. A-10 (Para. XV)) that the recoveries in this case were made outside a three-year period of limitations is without merit. In support of this limitations argument, petitioner cited in his complaint a single regulation, 20 C.F.R. 405.1885, that was adopted in 1974. See 39 Fed. Reg. 34515. That provision, now recodified at 42 C.F.R. 405.1885, has no relevance here. It concerns the time period within which a request must be made to reopen a determination by the Provider Reimbursement Review Board regarding the amount to be paid to a provider of

b. Especially against this background, petitioner's contention (Pet. 29-33) that Blue Shield's recoupment of previous payments through offset violated his due process rights because it impaired the obligation of contract is frivolous. As an initial matter, and contrary to the allegations in the complaint (Pet. App. A-8 to A-9 (para. XIII)), petitioner did not have a contractual relationship with Blue

---

services under Part A for services that *are* covered by the Act. See 42 U.S.C. 1395*oo*(a)(1)(A). This case, of course, concerns Part B claims and questions of coverage, not the amount of payment for services that are concededly covered.

Petitioner was first notified in June 1971 that his prior claims were being reviewed because of possible irregularities. At that time, regulations applicable to Part B determinations provided that a carrier's decision could be reopened within one year on the carrier's own motion or the motion of a party to the hearing "to allow for correction of a procedural or substantive defect in the proceedings." 20 C.F.R. 405.841 (1971). This provision appears to have been intended for the benefit of the claimant, and it presumably would not have barred all reexaminations of prior determinations—even, *e.g.*, where fraud was alleged. In any event, those regulations were revised in April 1974 to permit reopening for "good cause" within four years from the date of the notice of the prior determination and at any time when the prior determination "was procured by fraud or similar fault of the beneficiary or some other person" (42 C.F.R. 405.841(b) and (c)). Petitioner's conviction on 39 counts of submitting false claims for nursing home visits plainly would constitute "good cause" to reexamine similar claims submitted by petitioner; moreover, in this case, petitioner could be said to have been at fault, warranting a reopening at any time.

Petitioner does not elaborate upon the statute of limitations issue in his certiorari petition. He simply asserts in conclusory fashion (Pet. 38-39) that expansion of a statute of limitations in a way that deprives an individual of substantial property rights violates the Due Process Clause. But even if petitioner were correct that an applicable period of limitations in agency regulations was expanded in this case, it is well established that reinstatement of a remedy after the limitations period has run does not violate due process where, as here, running of the limitations period does not vest a party with substantive rights. See *Chase Securities Corp.* v. *Donaldson*, 325 U.S. 304 (1945), and *Campbell* v. *Holt*, 115 U.S. 620 (1885), upon which petitioner relies (Pet. 39). Cf. *United States* v. *Caceres*, 440 U.S. 741 (1979).

Shield or the Secretary. Whatever right to reimbursement he had derived solely from the assignment of claims to him by participants in the Medicare Part B program. See *United States* v. *Erika, Inc., supra*, 456 U.S. at 207 n.7. The participants in turn have claims to benefits that arise directly under the statute; those benefits are no more contractual in nature than are the benefits paid to participants under other titles of the Social Security Act. See *Weinberger* v. *Salfi*, 422 U.S. 749, 771-772 (1975); *Flemming* v. *Nestor*, 363 U.S. 603, 608-611 (1960); cf. *United States Railroad Retirement Board* v. *Fritz*, 449 U.S. 166, 174 (1980). But even if petitioner were correct that the statute could be said to create implied-in-fact contracts between the Secretary or the carriers and each of the more than 27 million Part B beneficiaries, one of the terms of those contracts would be the provisions in 42 U.S.C. 1395u(b)(3)(B)(ii) and 1395gg(b) that permit recoupment of payments if it is determined that a prior coverage determination was incorrect. See *United States* v. *Erika, Inc., supra*, 456 U.S. at 211 n.14.

Petitioner's contention that Blue Shield's prior adjustment and payment of his claims created a contract by means of accord and satisfaction that could not be impaired through later recoupment is frivolous for much the same reason. Blue Shield acts as a neutral adjudicator, not an adversary, in the payment of claims (*Schweiker* v. *McClure, supra*, 456 U.S. at 195, 197 n.11), and its determination of the amount, if any, of benefits that may be paid on a particular claim therefore no more constitutes an "agreement" of accord and satisfaction between it and the claimant than the judgment of a court creates such an agreement between the court and the litigants. But even if petitioner were correct that the initial payment of benefits constituted some form of agreement of accord and satisfaction, one of the terms of that agreement would be that it is

subject to the adjustment and recoupment provided for under 42 U.S.C. 1395u(b)(3)(B)(ii) and 1395gg(b).

c. The remaining constitutional issue raised in the complaint is that Blue Shield violated due process by failing to provide petitioner with a notice of each individual past claim in dispute or to provide him with an opportunity for a hearing prior to the initial withholding of funds in 1971 or the subsequent recoupment. See Pet. App. A-7 (para. IX), A-9 to A-10 (para. XIV), A-12 to A-13 (paras. XVIII(2) and (4)). These contentions are now moot. After Blue Shield conducted its audit of petitioner's past claims, he was furnished with an itemization of the claims that were being questioned (R. 134-149), and he since has had a hearing on those claims. It is now beside the point whether he should have had more complete notice or a hearing before funds first were withheld in 1971 or before the initial decision by Blue Shield in 1975 that payments in fact had been made for services that were not medically necessary and that the amounts in question would be recouped.

Petitioner also contends in the certiorari petition (Pet. 25-29) that the delay in holding a hearing after funds were withheld in 1971 violated his due process rights. This issue of delay was not specifically raised in the complaint and therefore is not before the Court. In any event, this issue, too, now is moot, since petitioner has had a hearing on the disputed claims. Petitioner does not allege in the complaint or certiorari petition that he was prejudiced by the passage of time prior to the hearing. See *United States* v. *Lovasco*, 431 U.S. 783, 790 (1977).

Moreover, the passage of time in this case was not unreasonable under the circumstances. It plainly was appropriate for Blue Shield, in 1971, to suspend or withhold payments to petitioner until it completed an investigation into possible irregularities on past claims. Petitioner's

indictment and subsequent conviction in 1972 substantiated the need to review his past claims before reimbursing him on new ones. In addition, it was sensible not to institute formal administrative proceedings while the parallel criminal and civil proceedings were pending. Once those proceedings were completed, Blue Shield moved expeditiously to complete an exhaustive audit of several thousand claims, and to review the results of that audit at petitioner's request. Subsequent delays in scheduling the hearing were largely attributable to petitioner (see note 3, *supra*).[8]

---

[8]Petitioner briefly asserts (Pet. 4, 15) that due process required that the patients who had assigned their claims to him should have been given notice of the denial of coverage. Apart from the obvious standing problems in raising such a claim, petitioner nowhere alleges or demonstrates that those patients were in any way adversely affected by the recoupment of overpayments from him. Under 42 U.S.C. 1395u(b)(3)(B)(ii), petitioner could not recover from those patients if recoupment was made more than three years after notice of payment was sent to them, if they were without fault in incurring the expenses.

Petitioner also makes a passing assertion (Pet. 30) that reimbursement rules adopted in 1971 were applied retroactively to his case. Contrary to petitioner's contention, however, the Act itself always has permitted payment only for "reasonable and necessary" services. 42 U.S.C. (& Supp. IV) 1395y(a)(1). The guidelines adopted in 1971 simply announced a rule that one visit per month to a nursing home patient would be deemed "reasonable and necessary," while more frequent visits would require documentation. See page 5, *supra*. Moreover, petitioner was aware in 1969 that problems could arise with respect to reimbursement for more than one visit per month. See R. 133 (letter to petitioner from Blue Shield relating to similar policy under Medi-Cal Program).

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

REX E. LEE
Solicitor General

J. PAUL MCGRATH
Assistant Attorney General

NICHOLAS S. ZEPPOS
Attorney

MAY 1983

DOJ-1983-05

No. 82-1217

IN THE SUPREME COURT OF THE UNITED STATES

October Term, 1982

SEYMOUR R. MATANKY, M.D. and
CORBIN MEDICAL CLINIC,

Petitioners,

vs.

UNITED STATES OF AMERICA,
SECRETARY OF HEALTH, EDUCATION
AND WELFARE, AND BLUE SHIELD OF
CALIFORNIA, a corporation,

Respondents.

Judicial Review Pursuant to Article III,
U.S. Constitution and Title 28 U.S.C., Section 1491, and
Fifth Amendment, U.S. Constitution of Medicare Act, Part B
Claims Administrative Review

REPLY BRIEF OF PETITIONERS ON PETITION FOR WRIT OF CERTIORARI

JOAN CELIA LAVINE
Attorney at Law
123 North Hobart Boulevard
Los Angeles, California 90004
(213) 627-3241

Attorney for Petitioners
Seymour R. Matanky M.D., and
Corbin Medical Clinic

TOPICAL INDEX

TABLE OF AUTHORITIES

Cases

Constitution

Statutes

No. 82-1217

IN THE

UNITED STATES SUPREME COURT

OCTOBER TERM, 1982

SEYMOUR R. MATANKY, M.D.
CORBIN MEDICAL CLINIC,

Petitioners,

vs.

UNITED STATES OF AMERICA.
SECRETARY OF HEALTH, EDUCATION
AND WELFARE, AND BLUE SHIELD OF
CALIFORNIA, a corporation,

Respondent.

Judicial Review Pursuant to Article III,
U.S. Constitution and Title 28 U.S.C.,
Section 1491, and Fifth Amendment,
U.S. Constitution of Medicare Act,
Part B Claims Administrative Review

REPLY BRIEF OF PETITIONERS ON PETITION FOR WRIT OF CERTIORARI

Come now the petitioners Seymour R. Matanky, M.D. and Corbin Medical Clinic and set forth their reply brief to the respondent The United States of America's "Brief for the Respondents in Opposition,"

filed herein in the above entitled Court on or about May 19, 1983, to-wit:

1. The respondent The United States of America (referred to hereinafter as "the Government") wholly fails to address directly and clearly, what is considered to be the pivotal issue herein, and the critical, substantial constitutional importance to the handling and judicial review of administrative claims under the Medicare Act, Part B, as contained in Title 42 U.S.C., Section 1395ff, et. seq.: whether physicians and patients have a right to judicial review by duly appointed, presiding federal judges under Article III and the due process clause of the Fifth Amendment of the United States Constitution, particularly after adjudication of their claims and grievances by privately employed hearing officers, assigned on a delegation of administrative authority to private insurance carriers, to review constitutional claims, allegations and grievances under Article III, United States Constitution. (Weinberger v. Salfi,

422 U.S. 749; Califano v. Sanders, 430 U.S. 109; Johnson v. Robison, 415 U.S. 361; Chelsea Community Hospital v. Michigan Blue Cross, 630 F.2d 1130).

This failure to respond, specifically, to this critical issue appears to be an admission by the respondent Government that petitioners, like all physicians and patients, are entitled to have access to duly appointed and presiding Article III, U.S. Constitution judges, and may not be deprived of these constitutional rights by legislation or administrative regulation.

2. Each of the issues raised by petitioners is constitutional in nature, and couched in terms of substantial and material, prejudicial, substantial, per se, plain, harmful consitutional level violations. (Chapman v. California, 386 U.S. 18, 17 L.Ed.2d 705.)

The respondent Government misreads and overlooks the specific statement by this United States Supreme Court in United States v. Erika,

Inc., 456 U.S. 201, 72 L.Ed.2d 12, 102 S.Ct. 1650 in its most inaccurate and inappropriate remark that petitioners seek to avoid the United States v. Erika, Inc. ruling.

This United States Supreme Court stated in United States v. Erika, Inc., 456 U.S. 201, 72 L.Ed.2d 12, at 20, in footnote 14, that it did not reach any constitutional level issues to-wit:

> "14. . . In response to questioning at oral argument, respondent (Erika, Inc.) answered that it was asserting a constitutional right to judicial review of Prudential's Part B determination. Tr of Oral Arg 39. Respondent, however, neither argued this ground in the Court of Claims, included it among the questions presented to this Court in its brief in opposition or in its brief on the merits, nor devoted any substantial briefing to it. We consequently do not address the issue. See this Court's Rules 34.2 and 22.1: cf. Neely v. Martin K. Eby Construction Co., Inc. 386 US 317, 330, 18 L.Ed 2d 75, 87 S Ct 1072 (1967)." (Erika, Inc. clarification added on line two of quote.

This Court did not reach or decide the issue of the right to have access to Article III federal judges in United States v. Erika, Inc., 456 U.S. 201 for judicial review of administrative determinations.

3. If the United States Court of Claims does not have jurisdiction over the monetary claim, as asserted by the respondent U.S. Government, although the U.S. Court of Appeals for the Ninth Circuit so concluded in Drenan v. Harris, 606 F.2d 846, and although the U.S. District Court for the Central District of California so concluded, based on Drenan v. Harris, supra, in transferring this matter at bar to the U.S. Court of Claims, then it had no subject matter jurisdiction to make a determination on the merits of the federal constitutional level claims involved and materially, substantially, plainly erred in purporting to do so. Its order is void for lack of jurisdiction.

It appears the U.S. Court of Claims bypassed and failed to adjudicate the first, foundational issue herein, that is, whether it had the jurisdiction to determine jurisdictional issues in the first place. The respondent Government clearly advocates and concludes that the U.S. Court of Claims did not have this jurisdiction to make a

determination on subject matter jurisdiction. It would appear this Court holds a U.S. District should make those determinations, as reflected in Schweiker v. McClure, 72 L.Ed.2d 1. Petitioners herein moved to transfer this action back to the U.S. District Court where the complaint was first filed, and again so moved.

It is respectfully submitted that whoever hears and determines the matter is required to evaluate the concstitutional claims on the merits whether a claim has been stated, not merely dismiss the involved action. (Hagans v. Lavine, 415 U.S. 528; Bell v. Hood, 327 U.S. 678, 90 L.Ed. 939.)

Even the respondent the Government now attempts to litigate factual issues concerning constitutional issues of estoppel before this Court and for the first time, seeing that its position is meritless. But the litigation of facts is for a trier of fact at the trial level, not on a petition for writ of certiorari in the United States Supreme

Court on appellate review. In a back-handed way, the Government agrees with petitioners that material, constitutional, factual issues are present here concerning which the petitioners are entitled to a trial on the merits. (Conley v. Gibson, 355 U.S. 41, 2 L.Ed.2d 80 (1957); Bell v. Hood, 327 U.S. 678, 90 L.Ed. 939; Leone v. Aetna Casualty & Surety Co., 599 F.2d 566.)

This is not the trial court. The issues discussed concerning other litigation about Dr. Matanky were not raised below. Neither at the administrative level, nor in its answer to the complaint of Dr. Matanky (see, Appendix B-1 through B-8 of petition for writ of certiorari) nor in its motion to dismiss in the U.S. Court of Claims did the Government raise any collateral factual issues concerning other unrelated litigation Dr. Matanky was involved in. Those matters were excluded from consideration. Therefore, petitioners move to strike said references on the ground that the respondent has no standing to raise these

matters in this Court, having waived its opportunity to do so in the lower courts and in this Court.

4. As this United States Supreme Court has stated in Hagans v. Lavine, 415 U.S. 528, at 542, 39 L.Ed.2d 577, 94 S.Ct. 1372, to-wit:

> "We think the admonition of Bell v Hood, 327 US 678, 90 L Ed 939, 66 S Ct 773, 13 ALR2d 383 (1946), should be as followed here:
>
> > 'Jurisdiction . . . is not defeated as respondents seem to contend, by the possibility that the averments might fail to state a cause of action on which petitioners could actually recover. For it is well settled that the failure to state a proper cause of action calls for a judgment on the merits and not for a dismissal for want of jurisdiction. Whether the complaint states a cause of action on which relief could be granted is a question of law and just as issues of fact it must be decided after and not before the court has assumed jurisdiction over the controversy. If the court does later exercise its jurisdiction to determine that the allegations in the complaint do not state a ground for relief, then dismissal of the case would be on the merits, not for want of jurisdiction.' Id., at 682, 90 L Ed 939, 13 ALR2d 383 (citations omitted).[10]"

5. The respondent Government asserts for the first time in this Court that petitioner's constitutional allegations are "frivolous," as a basis for denying a petition for writ of certiorari. This bootstrap argument is meritless, and petitioners move to strike it on the grounds that it has not been litigated below in its "merits" and is raised for the first time in this Court on appellate review.

This Court also stated in Hagans v. Lavine, 415 U.S. 542 at 542-543, 39 L.Ed.2d 577:

> "[7] As was the case in Bell v Hood, we cannot 'say that the cause of action alleged is so patently without merit as to justify, even under the qualifications noted, the court's dismissal for want of jurisdi ction.' Id., at 683, 80 L Ed 939, 13 ALR2d 383. Nor can we say that petitioners' claim is 'so insubstantial, implausible, foreclosed by prior decisions of this Court or otherwise completely devoid of merit as not to involve a federal controversy within the jurisdiction of the District Court, whatever may be the ultimate resolution of the federal issues on the merits.' Oneida, 414 US 66, 666-667, 39 L Ed 2d 73, 94 S Ct 772 (1974). (Citations omitted.)"

Constitutional claims are entitled to review in the appropriate trial level federal courts, and your petitioners are entitled to equal protection and access to the court to have same litigated as they meet the above set forth pleading standards. (United States v. James Stewart Co., 336 F.2d 777 (9th Cir. 1964); Conley v. Gibson, 355 U.S. 41.) Due Process issues about recoupment and estoppel to recoup due to the bar of the statute of limitations are factual issues concerning which your petitioners are entitled to have a trial on the merits by an Article III judge.

6. If the U.S. Court of Claims must dismiss for want of jurisdiction, it did not have power to decide the case one way or the other. (The Fair v. Kohler Die & Specialty Co., 228 U.S. 22, 25, 57 L.Ed. 716, 33 S.Ct. 410; Hagans v. Lavine, 415 U.S. 528, 39 L.Ed.2d 590). This Court has the jurisdiction and mandate of the U.S. Constitution to remand this case to the U.S. District Court for trial of constitutional issues.

WHEREFORE, petitioners pray for reversal.

Dated June 3, 1983.

Respectfully submitted,

JOAN CELIA LAVINE

Attorney for Petitioners